SCHOOL NURSING AND INTEGRATED CHILD HEALTH SERVICES

A PLANNING AND RESOURCE GUIDE

**for schools, health departments,
and primary care providers
in Kansas communities**

**KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
BUREAU FOR CHILDREN, YOUTH & FAMILIES
CHILDREN & FAMILIES SECTION
2005**

In recent years there has been increased recognition at both the federal and state level of the need for Local Health Department Child and Adolescent Health Programs, Primary Care Providers, and School Health Programs to function more effectively and efficiently as integrated child health programs. In the effort to be more comprehensive and less categorical, and in recognition that public health nurses, office nurses and school nurses serve much of the same population, the KDHE Division of Children & Families has designed this guide as an integrated resource. From this date forward, there will be only one on-line "manual" entitled **School Nursing and Integrated Child Health Services: A Planning and Resource Guide**.
This new resource, in combination with the **Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents** constitute the Kansas Department of Health and Environment's standards and guidelines for the provision of all MCH Child and Adolescent Health and School Health Programs, and replace the printed manuals published in the mid-1990's titled **Children, Youth, and Families Health Services Manual, Part II: Children and Youth** and **Children, Youth and Families Health Services Manual, Part III: Partnerships in School Health**.

Thanks and appreciation goes to **Jeff Coen, Rick Bryant and Valetta Striblin** who provided editorial and technology assistance.

Introduction/Use of This Resource

School Nursing and Integrated Child Health Services: A Planning and Resource Guide, like the School Health Manual Fourth Edition, 1995 (Vol. III), and its predecessors, was really developed over a period of years with input from school and public health nurses, educators, private and public health care providers, school administrators, parents, and academicians from across the state and around the country. It looks different and will function differently than the School Health Manual (Volume III) and the Child and Adolescent Health Manual (Volume II) previously printed by the Kansas Department of Health and Environment, but contains the same essential kinds of information and guidelines. However, it is—and will continue to be—a work in progress. Throughout these pages you will find many interactive web page links to resources and materials that are essential in the provision of child and adolescent health programs. These references allow for a reduction in the size of the main body of this resource, while providing access to resources that change frequently or may represent new developments. You may save the body of this resource to your computer and/or print it, or print specific sections, but be aware that it will be updated continuously on the web, so you are encouraged to check the KDHE-BCYF school health site frequently to make sure you have the most current information available, bookmark the site at: www.kdhe.state.ks.us/bcyf/c-f/school.html

This guide is **not** intended as a substitute for comprehensive texts on public or school health, federal or state laws or regulations, information and management systems, school or public health nursing practice. It cannot be all things to all people. You will not find all the answers here, but hopefully you will find direction and guidance to appropriate sources for the most current and relevant information. And *please*, contact us about information you see that you know to be incorrect or that is not current.

What this guide **can** do is to provide the basic information and/or guidance and resources necessary for school districts, school nurses, health departments, private health care providers and community partners working together to design and develop safe and effective child health systems.

It is our sincerest hope that these systems in turn will support the health and academic success of Kansas' children by breaking down and removing health-related barriers to learning and promoting the health and well-being of students, staff, and families in the schools and communities of Kansas.

If you have any questions or comments, please call:
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School Health Programs

History of School Health

In the early 1900's, the work of Lillian Wald in the schools, families, and neighborhood communities of New York City established a framework for nursing practice that public health nurses in every setting have come to recognize as the gold standard for community health practice. With her assistants, Wald made daily inspections in New York's schools for fever, rashes, lice and other contagious conditions. She and her assistants made home visits and educated children and families regarding health promotion and disease prevention, as well as appropriate care for the sick.

Wald recognized the need to keep the students who should be in school there and ready to learn, and to keep those who were ill from spreading disease in the schools. It was she who persuaded the New York Board of Education to hire nurses in the schools. By the mid-20th century, improvements in housing and public health practice—including sanitation, vaccines, and antibiotics—relieved the need for the "contagion watch" and the provision of first aid, health screenings, and health education became the function of public health nurses in schools.

Fifty years later, school children were reported to be the "healthiest group in the population"—an assertion still widely accepted by both schools and health care providers. However, while school children as a group die less frequently than infants and the elderly and are less physically disabled than the aged, it is also true that certain morbidities are confined to children—child abuse, neglect, and delinquency for example—and that disruptions in childhood such as pregnancy, injury and disability can adversely affect all subsequent development. Chronic health conditions in children have longer-term disability implications compared to similarly afflicted adults, and children are more vulnerable to the physical, emotional, and social hazards of their environment. Much of the chronic disease and over half of the deaths in this population are preventable, and schools present the only environment in which certain disease states, such as learning problems, are manifested. *Code Blue: Uniting for Healthier Youth,* a 1990 report stated, "Never before has one generation of children been less healthy, less cared for or less prepared for life than their parents were at the same age."

Attending school is the major activity of most children and adolescents in Kansas. This guide to School Nursing and Integrated Child Health Services is grounded on two basic principles:

- A very real connection exists between the health of children and adolescents and their ability to learn optimally.
- It is in the best interest of children and families, schools and communities to provide basic health promotion and prevention services and to coordinate access to primary health care services where kids spend most of their day—in the school setting

The Kansas State Department of Education (KSDE) and the Kansas Department of Health and Environment (KDHE) have long supported school health services designed to promote general student health and safety, and that recognize the special health care needs of children and adolescents with chronic health conditions and acute illness. In addition, both agencies support extended school health services that are locally supported and determined based on the need of the local community, that are fully disclosed through local discussions involving parents and community members, and that allow parents the option of declining any or all health services for their children.

Until recently, school nursing and health services in Kansas focused largely on mandated screenings for vision and hearing, immunization compliance and reporting, first aid, and the occasional administration of prescription medications for special needs students.

The reauthorization of IDEA in 1997 and the enforcement of Section 504 of The Americans With Disabilities Act began to move schools and school nursing toward the realization that more students with more severe disabilities and chronic health conditions were going to require a refocusing of school health efforts and priorities.

In 2001, the KDHE Children & Families Section emphasis for child health, school nursing and school health began moving toward integrated health services, the development of a statewide coordinated school health initiative, and community partnerships for children's health—pursuing the goal of a medical home and a primary care provider for every Kansas child and adolescent as well as enrollment in a public, private, or governmental health care plan.

The Kansas Department of Health and Environment (KDHE) through the Division of Children & Families School Health Program provides consultant services to public and private schools and local health departments in Kansas, as well as information and resources to school and health department personnel and community health partners. In addition, through a competitive request for proposals (Comprehensive School Health Center Initiatives), Children & Families makes available monies to communities interested in establishing Integrated School Health Service Centers through the school nurse office. The goal of this funding mechanism is to maximize the utilization of existing community resources to positively impact the health of children and adolescents.

The New Millennium

The 21st century finds the public health advocates who work in and with the schools at a major crossroads: The health screenings, first aid and assistance in health classes of past decades can no longer be the primary focus of the nurses working in schools. Contemporary school nursing practice addresses a population presenting multiple urgent, varied and increasingly complex health problems and health care needs. The new morbidities of violence, substance abuse, suicide, homelessness, pregnancy and STDs have to be addressed in the context of increasingly diverse, unstable, and dysfunctional family structures.

The State Child Health Insurance Program (SCHIP) created through the Balanced Budget Act of 1998 and known in Kansas as HealthWave (includes Title XIX—Medicaid and Title XXI—CHIP) creates many new avenues for health care reimbursement for children in schools, but will require school nurses to do some rethinking of what kind of programs and services should comprise the majority of their practice. Faced with huge statewide budget deficits in the decade of 2000s, Kansas schools have sustained a severe blow that may well require large cuts in school health services for years to come unless some method for creating revenue can be envisioned and enacted.

Early intervention programs for developmentally delayed children from birth to age three, and inclusion of children with severe multiple handicaps and debilitating chronic conditions in the classroom under IDEA illuminate a burgeoning need for nurses to broaden their practice arena and expertise to include populations and skills enhancements traditionally not addressed in the school setting. The more complex problems are potentially life threatening, and even the most "mundane" every day problems require the well-honed decision making and clinical nursing skills found only in a registered professional nurse with school and public health specialty experience and expertise.

Registered nurses are the only professionals in the school setting prepared to assess and address the health issues and needs that students bring with them to school, and to evaluate health care outcomes and their impact on educational outcomes. Yet barriers and challenges exist that make effective response to the health needs of today's students difficult at best. As a profession, school nurses must learn to act locally and think globally, addressing these barriers from individual, group, and systems perspectives.

As you move through the pages of this guide, keep in mind always that in addition to providing care for the children, adolescents, families and staff with whom we engage on a daily basis, together we **must**:

- Increase the participation of school and public health nurses in policy making. Locally, we need to partner with boards of education, as well as health and school administrators to uphold the legal requirements within both the education and health fields, and overcome barriers to effective professional school nursing practice. At all levels, school and public health nurses must be a part of developing health information, data management and service systems that provide the information and data necessary to monitor trends and that drive policy development and funding decisions regarding child and adolescent health.
- Decrease the isolation of school nurses by partnering with school administrators and public health officials to establish organizational structures that provide clinical supervision and consultation for nurses, enhancing the provision of safe and appropriate school health services, fostering professional growth, and inviting and initiating collaborative research related to both health and education outcomes in the school setting.
- Facilitate an interagency awareness of the professional school nurses' unique role in interpreting the complex health needs of student populations by facilitating ongoing dialogue with community organizations, local and state health and human services providers and school administrators and staff, that fosters a mutual commitment to and responsibility for both student health and educational progress.
- Ensure that all professional school nurses have educational preparation and demonstrated competency in the specialty practices of school nursing and public health nursing. Determining what a practitioner must know and do to effect desired outcomes provides very real and compelling benefits. Professional certification, while different than practice-based competency, endorses the core knowledge for competent practice and promotes safe, quality services for students beyond those assured by state licensure. Competency standards for all school nurses help to eliminate disparities in services and ensure that all child and adolescent health services in schools are provided by equally prepared and competent practitioners.
- Develop and implement innovative funding mechanisms for school health services, and establish inter and intradisciplinary working relationships within and outside school systems to increase awareness of the integrated nature of the education and health missions.

Together, we **can**!

The Case for School Nursing and School Health in Kansas

Schools in virtually every city and town in Kansas today are filled with children and adolescents confronted with a broad array of complex health and education issues. Everything from the specter of AIDS to the implications of the "information age" that even ten years ago seemed unimaginable are a part of the fabric of life for today's school communities. On September 11, 2001, the first attack on civilians on American soil killed thousands of innocents altering our perceptions forever, and forcing all of us to drastically reorganize our worldview. Yet some things never change. Kids still need to be loved, cared for, listened to, cheered on, and assured that they are important. When children and adolescents experience such support they have a chance to become healthy, resilient, successful lifelong learners despite the turmoil that surrounds them. That can only happen when the adults in a child's life are willing to work together to nurture that child's growth, learning, health, and wellness.

School nurses and public health nurses in Kansas have always delivered components of primary health care and preventive services in a user-friendly community setting in a cost-effective, accessible way that supports the complete inclusion of a very diverse population. Yet, as the new millennium begins, we are truly at the crossroads of our future. For a multitude of external reasons—most more apparent to nurses than to our educator counterparts—(health care reform, the new need for syndromic surveillance, the changing emphasis in nursing education, decreasing PCP and nurse provider populations, managed care, etc) child and adolescent health nursing in Kansas in 2005 is primed to become fully integrated into both the health care delivery and education systems.

Although certainly a positive development, this new possibility creates demands, expectations, and opportunities that school and public health nurses in Kansas have never experienced before. As we seize the opportunity and demonstrate our ability to meet Kansas' diverse child and adolescent health care needs more effectively and efficiently in the schools, we have an excellent opportunity to establish school health programs as the most appropriate entry point for school age children into the health care system. If school nurses can visibly and consistently connect the provision of appropriate health screening, health supervision and health care to learning outcomes, the basis for a full partnership with the educational community can be established as well.

Kansas has nearly 500,000 students in over 1600 schools in sparsely populated frontier to densely urban communities. The KSDE Report Card for 2003-2004 indicates that 13.5% of the students have disabilities. In the 2004-2005 school year, 13.0% of the students enrolled were categorized special education.

- In 2002, **6,727** Kansas children ages 5-14 spent a total of **22,551** days in hospitals with an average length of stay of 3.4 days.
- In 2002, **869** Kansas children ages 5-14 were hospitalized with mental illness. The 2001 Surgeon General's Report on Mental Health states, "Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care".
- In 2002, **828** Kansas children ages 5-14 were hospitalized due to injury and poisoning. Every unintentional injury or poisoning hospitalization was preventable.
- In 2002, **1,168** Kansas children ages 5-14 were hospitalized with respiratory conditions. On average, in a classroom of 30 children, about three are likely to have asthma. Over 6 million children under 18 years of age are reported to currently have asthma, and asthma

is one of the leading causes of school absenteeism. (downloaded from http://www.cdc.gov/HealthyYouth/healthtopics/)

- In 2003, **10.5/1,000 (1632)** Kansas girls between the ages of 10-17 were pregnant

- In 2003, **207** Kansas children and adolescents ages 5-19 died. 57% of these deaths were due to unintentional injuries.

- National data from 2003 indicates a birth rate of 22.4/1000 females ages 15-17.

- In 2003, Kansas data showed an overall teen birth rate of 20.0/1,000 females ages 15-17 years. The Hispanic teen birth rate for 2003 was 60.5/1,000 population.

- Nationally, approximately **20%** of 9-17 year olds have a diagnosable mental disorder each year. School failure, substance abuse, violence, and suicide are potential outcomes of mental and behavioral disorders and serious emotional disturbances (SEDs).

- In 2003 unintentional injury is the leading cause of death for Kansas's adolescents ages 15 to 19.

- Motor vehicle crashes are the leading cause of death for adolescents from 15 to 18 years of age. Teen drivers account for **6.7%** of all KS registered drivers but **20.1%** of all crashes. **13%** of all drivers involved in fatal crashes were teen drivers. Most teen crashes occur between 3-4pm. **85%** of all teen fatalities were not buckled up.

- YRBSS National school-based survey conducted by CDC among student in grades 9-12 during February to December 2003, indicate: **22.4%** had used marijuana, **4.1%** had used a form of cocaine, **3.9%** sniffed glue or spray to get high one or more times during the 30 days preceding the survey; **7.6%** used methamphetamine one or more times during their lifetime; and **11.1%** used ecstasy one or more times during their lifetime. Kansas does not have any weighted data, but it would be reasonable that Kansas would have similar statistics. This same survey study indicated **44.9%** drank one or more drinks of alcohol, **28.3%** drank 5 or more drinks of alcohol, **30.2%** rode with a driver who had been drinking alcohol, **12.1%** drove after drinking alcohol one or more times during the 30 days preceding the survey.

Any efforts to support and promote the healthy development of Kansas' children and to eliminate disparities in health care in order to remove barriers to learning must focus on empirically supported strategies that are implemented in a coordinated manner. For this reason, **School Nursing and Integrated Child Health Services In Kansas: A Planning and Resource Guide** focuses on six core elements as we move into the 21st century. These elements enumerated on the following page constitute the theme of the text and links that comprise the rest of this guide, and represent the direction for Child and School Health embodied in national standards and best practices, from the American Academy of Pediatrics to the National Association of School Nurses. Become familiar with them. Print them out and look at them often. Make them a part of your daily routine and use them in planning budgets, programs, services and partnerships.

CHILDREN AND FAMILIES
CORE ELEMENTS OF
MCH CHILD HEALTH NURSING PRACTICE IN KANSAS

- **Coordinated School Health Services**

- **Uniform guidelines (Bright Futures) for health supervision of infants, children, and adolescents for all health care providers, including primary care providers, school nurses and public health nurses**

- **Development and implementation of school nurse competencies as the key to eliminating disparities in access to basic health care for all Kansas children and adolescents**

- **Utilization of desktop and handheld computer technology as an essential—not an optional—tool for all health professionals to promote and improve the practice of health care and health promotion for Kansas children in the 21st century**

- **Systematic collection, analysis and dissemination of health and education data and information for the purpose of assessment, program planning, and evaluation of child and school health programs**

- **Integration of public health and social service missions into the schools through collaboration and rethinking of traditional service delivery structures and mechanisms**

Financing School Health Services

School Health Programs in Kansas have traditionally been funded at the local level through the general education fund. In addition, some school districts have chosen to pursue funding for school-based or school-linked health services. In school districts where the health of students is perceived to be closely linked to academic achievement and performance, monies have been allocated to ensure the presence of school nurses, health room supplies and equipment. While all schools in Kansas are funded using the same school finance formula, some school districts simply lack the local support to employ full time nurses, or have chosen to put more monies into direct student services, leaving little or no fiduciary support for health services.

At this point in most school districts in Kansas, any establishment or expansion of school health services will require some innovative and creative funding. There are at least two basic steps school districts or individual school sites must take in order to look at school health and school nursing funding sources. These "baby steps" are absolutely essential to the healthy development of school health services.

- A school health advisory committee or planning committee needs to be established or activated in order to ensure school and community support for health services
- The advisory committee must establish whether or not the district already receives funds that could support new or expanded initiatives, if the district is eligible for such funds, if the district makes allocations of such funds to school sites, if the funds can be earmarked specifically for school health and school nursing, and if the school is free to pursue funding independently.

Potential sources of state and federal funding for school health/school nursing programs are listed below:

Kansas Department of Health and Environment (KDHE) Comprehensive School Health Center Initiative

Thousands of school age children in Kansas have limited access to comprehensive health services because of financial, geographical and other barriers to care. Comprehensive School Health Centers (CSHCs) can improve access to primary care for underserved children and youth. CSHCs bring comprehensive primary care services to the place where children and youth are during the day and address critical health problems that make it difficult for students to learn. These grants can be made directly to the school district; however, it is imperative that they collaborate closely with their local health department and primary care providers. Either the local health department or the school district can operate as the fiscal agent. The grant guidance materials are available from your local health department around the first of February, or you can contact Jane Stueve (jstueve@kdhe.state.ks.us) or Ileen Meyer (imeyer@kdhe.state.ks.us).

The Request for Proposal (RFP) for Comprehensive School Health Center Initiatives can be accessed at www.kdhe.state.ks.us/bcyf/c-f/school.html

The No Child Left Behind Act of 2001 re-authorizes the Elementary and Secondary Education Act (ESEA) of 1965, the primary bill funding education. This most sweeping reform of Education law since the inception of the Department of Education contains a little-publicized provision that would allow local school districts to use Federal funds to hire and support school nurses. Rep. Carolyn McCarthy (D-NY) - one of the three nurses in Congress -championed the school nurse provision. It is her intention to help place a nurse in every school in the nation. The School Nurse Amendment under the Innovative Programs portion of Title IV allows schools to use funds to hire school nurses for their schools. Previously, funds were not specifically earmarked for this purpose.

School nurses are only one of a long-list of approved uses for these funds - including programs to recruit and train teachers, acquisition of instructional materials and technology, disadvantaged student programs, magnet schools, charter schools, etc. Therefore, it is imperative that school health personnel be informed about the Act and its potential for funding school nurses. The No Child Left Behind web page can be accessed at http://www.ed.gov/nclb/landing.jhtml?src=mr

Title I (Services for Disadvantaged Children) makes available funding for schools to provide additional health and social services to selected students and their families. The website for Compensatory Education and Title I can be accessed at http://www.doe.state.in.us/TitleI/welcome.html

Title II (Professional Development) supports staff training that fosters school reform efforts. The website for Title II can be accessed at www.ed.gov/pubs/ArtsEd/part5.html

Title IV (Safe and Drug Free Schools and Communities) supports safe, violence-free, and drug-free environments for teaching and learning. The website for Title IV can be accessed at: www.ed.gov/offices/OESE/SDFS/index.html

Title XI (Coordinated Services) allows school districts to use up to 5% of funds received under the act to develop, implement, or expand a coordinated services project. Funds must be used to coordinate and integrate services rather than to provide direct services.

Title V of the Social Security Act (Maternal and Child Health) Charged with the primary responsibility for promoting and improving the health of our Nation's mothers and children, the Maternal and Child Health Bureau (MCHB) draws upon nearly a century of commitment and experience. Early efforts are rooted in MCHB's predecessor, the Children's Bureau, established in 1912. In 1935, Congress enacted Title V of the Social Security Act, which authorized the Maternal and Child Health Services Programs--providing a foundation and structure for assuring the health of mothers and children now for more than 64 years. Today, Title V is administered by the Maternal and Child Health Bureau as part of the Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

Child health grant opportunities are continuously updated on the MCH website, including grants for Family Centers, Systems to Address Family Violence, Distance Learning, Continuing Education and Development, Community-Based Abstinence Education, Leadership Education in Adolescent Health, Health Insurance/Financing for CSHCN, Community Integrated Systems, Healthy and Ready to Work National Center, Genetic Services, Hemophilia Centers, and Integrated Oral Health Systems. The MCHB website can be accessed at: mchb.hrsa.gov/

Funding is also available from organizations and associations such as:

AAP CATCH Planning Funds Program: Find a Pediatric Partner! This grant program supports pediatricians in planning a community-based child health initiative. Grants of up to $10,000 each are awarded each year on a competitive basis to pediatricians who want to assess and document the needs of children in the community, develop collaborative partnerships for planning the initiative, and successfully prepare for implementation of a program. Since its inception in 1993, the CATCH Planning Funds program has awarded planning grants to more than 150 pediatricians. The CATCH Planning Funds program is made possible through the generous support of Wyeth Lederle Vaccines and contributions to the AAP's Friends of Children Fund.
The AAP Community Pediatrics website can be accessed at: www.aap.org/commpeds/

AAP Healthy Tomorrows Partnership for Children Program The HTPCP is a collaborative partnership between the American Academy of Pediatrics (AAP) and the federal Maternal and Child

Health Bureau (MCHB). Healthy Tomorrows projects target low-income populations and address four key areas: access to health care, community-based health care, preventive health care, and service coordination. The program requirements include: pediatrician involvement; a two-thirds matching funds requirement; to ensure project sustainability, an evaluation component; technical assistance visits, an advisory board comprised of local community members, families, and program participants. To be eligible for funding, projects must represent a new initiative within the community or an innovative component that builds upon existing community resources.
The Healthy Tomorrows website can be accessed at http://www.aap.org/commpeds/htpcp/index.html

The Robert Woods Johnson Foundation The Robert Wood Johnson Foundation was established as a national philanthropy in 1972 and today it is the largest US foundation devoted to improving the health and health care of all Americans. Grantmaking is pursued in four areas: assurance that all Americans have access to basic health care at reasonable cost improving care and support for people with chronic health conditions, promoting healthy communities and lifestyles, and reducing the personal, social and economic harm caused by substance abuse — tobacco, alcohol, and illicit drugs.
The RWJF website can be accessed at www.rwjf.org/

The Foundation Center Grantmaker Websites Well maintained and regularly updated directories of annotated links to more than 2,000 grantmaker Web sites. The links are organized by grantmaker type, private foundations, corporate grantmakers, grantmaking public charities, and community foundations. The website can be accessed at: fdncenter.org/funders/

School Nursing Practice

School nursing has existed in America for at least 150 years for the purpose of supporting the educational mission of schools by preventing, removing, and/or reducing barriers to student learning. The emphasis of school health services has changed over time to reflect the needs of students, families and communities. In the past 15-20 years, school nurses have become increasingly more essential to America's schools. The deepening of that relationship has been motivated and supported, in great part, by such legal initiatives as Section 504 of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA and IDEA-Reauthorized 1997, and its predecessor, Public Law 94-142, all of which have blurred the line of distinction between schools and school health services.

Changes in society, the provision of health care, education, and in the family itself have increased the need and demand for school nursing and health services. New paradigms are evolving for school nursing services as school systems develop coordinated school health programs to address the diverse and complex health problems of today's students. In addition to physical health issues, schools must cope with problems caused by immigration, homelessness, divorce, remarriage, poverty, substance abuse, and violence. The mission of the schools, however, continues to focus on and promote academic learning. Health services in schools still tend to be seen as secondary—competing for space in an already crowded school day, school building, and school budget.

The National Association of School Nursing (NASN) defines school nursing as follows: "School nursing is a specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning." The National Association of School Nurses position statement on **Education, Licensure, and Certification of School Nurses** can be accessed at
http://www.nasn.org/positions/2002pseducation.htm
.

A new American Academy of Pediatrics (AAP) policy statement on **The Role of the School Nurse in Providing Health Services** issued in November, 2001 can be found at www.aap.org/policy/re0050.html

Professional Organizations

NASN

The **National Association of School Nurses** has as its mission "to improve the health and educational success of children and youth by developing and providing leadership to advance school nursing practice."

NASN benefits school nurses by speaking as one voice nationally, by increasing the visibility of school nurses, by advocating for minimum levels of preparation, by advocating for manageable nurse to student ratios, and by providing a forum for discussion of school health issues.

NASN is a non-profit specialty nursing organization incorporated in 1979, which represents school nurses exclusively. It has over 10,000 members and 50 School Nurse Association Affiliates, each of which elects a representative to the NASN Board of Directors.

NASN represents school nurses on national and federal committees which affect health services to children including the American Academy of Pediatrics / School Health Committee; NEA / Health Information Network; ANA / Nursing Care Reform; and the National Nursing Coalition for School Health.

NASN is the only organization that represents school nurses and school nursing interests exclusively, and it is an affiliate of the American Nurses Association. NASN also supplies written and oral testimony to congress about school health services on request and advises members of federal legislation affection school health services.

NASN helps to promote excellence in school health through its Continuing Education programs, educational materials, Newsletter, Journal of School Nursing, and collaborations with other professional organizations interested in the health of children and youth.

For more information, visit the NASN website at www.nasn.org/. To join NASN, visit the website at http://www.nasn.org/membership/membership.htm

KSNO

The mission of the **Kansas School Nurse Organization is** "to promote the lifelong achievement of Kansas children and together celebrate and enhance the specialized practice of professional school nursing through assessment, prevention, health education, early intervention, case management and collaboration".

Kansas school nurses have provided active services since 1915. KSNO was originally associated with Kansas State Nurses Association and included in the Public Health Section of KSNA. In 1952, a separate School Nurse Section was activated in KSNA.

For more information about KSNO, visit the website which is linked from the KDHE School Health Resources website http://www.ksno.org/

Affiliation NASN/KSNO

During the summer school nurse conference in July, 2004 the members of KSNO voted to become a unification state with NASN. As a unified state, Kansas would simultaneously join both NASN and KSNO, uniting Kansas school nurse voices with 11,000 plus other members across the nation and world. Unification will enhance the existing inter-relationships between Kansas and other national related associations and agencies. For more information about joining NASN/KSNO visit: http://www.nasn.org/membership/KSNASN.pdf or http://www.ksno.org
or email Cindy Galemore, Kansas NASN delegate at galemorec@olatheschools.com or Sue Holmes, current KSNO president at, sue@aplusp.org.

KSNO co-sponsors the **Kansas School Nurse Summer Conference** with KDHE each year during the last week in July at the Wichita Hyatt. New School Nurse Orientation is offered Monday and half the day Tuesday, with the General Conference beginning with lunch on Tuesday and ending on Friday. For more information, contact

Kim Moore, Associate Director, Wichita State University Conference Center
kimberly.moore@wichita.edu
316-978-6487 or
Stephanie Sauls, Conference Registrar, Wichita State University Conference Center
stephanie.sauls@wichita.edu
316-978-6493

American School Health Association (ASHA)

The American School Health Association unites the many professionals working in schools who are committed to safeguarding the health of school-aged children. The Association, a multidisciplinary organization of administrators, counselors, dentists, health educators, physical educators, school nurses and school physicians, advocates high-quality school health instruction, health services and a healthful school environment.

ASHA has more than 2,000 members in 56 countries. More than half the members practice in K-12 schools or advise and oversee health education or health services programs in schools or state agencies charged with managing school health programs.

The mission of the Association is to protect and improve the well-being of children and youth by supporting comprehensive school health programs. These programs significantly affect the health of all students, in preschool through grade 12, and the health of school personnel who serve them. School health programs prevent, detect, address and resolve health problems, increase educational achievement and enhance the quality of life. The Association works to improve school health education, school health services and school health environments. The Association also works to support and integrate school counseling, psychological and social services, food services, physical education programs and the combined efforts of schools, other agencies and families to improve the health of school-aged youth and school personnel.

For more information, visit the ASHA website at www.ashaweb.org/

American Nurses Association (ANA)

The American Nurses Association is a full-service professional organization representing the nation's 2.6 million Registered Nurses through its 54 constituent state associations and 13 organizational affiliate members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a

positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

For more information, visit ANA's website at www.nursingworld.org

Kansas State Nurses Association (KSNA)

The Kansas State Nurses Association is the professional organization for registered nurses in Kansas. It is a constituent of the American Nurses Association. The primary purpose of KSNA is to provide direction and a voice for the profession of nursing and nurses as leaders in health care.

The mission of KSNA is to promote professional nursing, to provide a unified voice for nursing in Kansas and to advocate for the health and well-being of all people.

The contact for the Kansas State Nurses Association is:

Terri R. Roberts, JD, RN, Executive Director
troberts@ksna.net
1208 S.W. Tyler
Topeka, Kansas 66612-1735
(785) 233-8638

For more information, visit KSNA's website at www.nursingworld.org/snas/ks/index.htm

Kansas Public Health Association (KPHA)

The Kansas Public Health Association (KPHA) is the oldest and largest organization of public health professionals in the state, representing more than 500 members from over 50 occupations/organizations.

KPHA brings together researchers, health service providers, administrators, teachers, and other health workers in a unique, multidisciplinary environment of professional exchange, study, and action.

KPHA is concerned with a broad set of issues affecting personal and environmental health, including federal and state funding for health programs, pollution control, programs and policies related to chronic and infectious diseases, a smoke-free society, and professional education in public health.

The contact for the Kansas Public Health Association is:

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Kansas Public Health Association
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School Nurse Education and Licensure

Nursing is a unique discipline with its own knowledge base and area of responsibility. Nursing includes the diagnosis and treatment of human responses to actual or potential health problems. The

practice of nursing is an art and an applied science that assists the individual to achieve maximum health within his/her own capacity. The uniqueness of school nursing stems from its perspective of care, concern for the whole person, respect for the individual rights and the promotion of wellness and growth.

Professional nursing education is based upon and combines a liberal education with the study of nursing science and practice. This forms the basis of making sound nursing decisions and a framework for consistent use of critical thinking. Professional nursing is built upon knowledge from natural science, behavioral science, and nursing science and theory.

School nursing is a separate and distinct specialty within the nursing and educational professions and therefore competencies in specified areas of health and education are needed in order for school nurses to act as health advocates for school age children.

There is no mandate for school health services or school nurses in Kansas, however the Kansas Department of Health and Environment, Children and Families Section, the National Association of School Nurses (NASN) and the American Academy of Pediatrics (AAP) recommend that registered, professional school nurses be employed to provide quality basic health care to students in the school setting.

The stated position of NASN is that school nurses should be registered nurses licensed to practice professional nursing by the state board of nursing. NASN promotes, supports, and represents the school nurse who has a high level of academic preparation, and believes that a baccalaureate degree from an accredited college or university is the preparation for entry into school nursing. While it is recognized that not all Kansas school nurses have baccalaureate preparation on entry into school nursing practice, KDHE and KSBE recommend that two and three year degree nurses pursue baccalaureate and advanced degrees in order to: (1) further develop the broad knowledge base outside the discipline of nursing that is so essential to the specialty practice of school nursing and (2) Create parity with the educational preparation required of all other professionals working in the school setting in Kansas.

The **American Academy of Pediatrics** policy statement on **The Role of the School Nurse in Providing School Health Services** can be accessed at www.aap.org/policy/re0050.html. The National Association of School Nurses position statement on **Education, Licensure, and Certification of School Nurses** can be accessed at http://www.nasn.org/positions/2002pseducation.htm

School Nurse Certification and Competencies

Until 2000, the Kansas State Department of Education (KSDE) certified school nurses in Kansas. With the restructuring of teacher licensing, the Department of Education has determined that because nurses are licensed by an outside regulatory agency (KSBN), the Department of Education should not be involved in the specialty certification process for another profession. As of September 2001, the *only* certification for school nurses in Kansas is available through the **National Board for Certification of School Nurses (NBCSN)**, a national certification process www.nbcsn.com. Nurses working in Kansas schools are encouraged to pursue this certification. Certification is an indication of current competence in a specialized practice area. NBCSN endorses the concept of voluntary periodic certification by examination for all school nurses. School nurse certification provides formal recognition of basic school nursing knowledge.

School nursing is a separate and distinct specialty within the nursing and educational professions and therefore competencies in specified areas of health and education are needed in order for school nurses to act effectively as health advocates for school age children.

The Kansas School Nurse Organization (KSNO) and KDHE Children & Families Section are currently working with the Kansas State Department of Education to adopt a set of **school nurse competencies** to be incorporated into the Department of Education Quality Performance Accreditation Standards for Kansas' schools. These will incorporate the *core competencies* of critical thinking, communication, assessment, and technical skills as well as the *core knowledge* components of health promotion, risk reduction and disease prevention, illness and disease management, information and health care technologies, ethics, human diversity, global health care, health systems and health policy.
If you would like to be a part of this working group, please contact Chris Tuck, ctuck@kdhe.state.ks.us or Cindy Galemore, galemorec@olatheschools.com

Professional Development

The registered professional school nurse must participate in continuous professional education to expand and update knowledge and practice to meet the increasing demands and expectations of the school and health community. In this rapidly changing world, it is no longer "enough" to have completed an associate degree program, a diploma program, a bachelor's program, a graduate or a postgraduate program. School nurses must interact with an increasingly complex world. The need to update skills and knowledge in a variety of rapidly changing areas, including health promotion, risk reduction and disease prevention, illness and disease management, information and health care technologies, ethics, human diversity, global health care, health systems and health policy cannot be overstated. School nurses are encouraged to pursue educational advancement and professional development whenever possible.
Scholarship and Financial Aid information is available through a number of sources including:
Kansas Board of Regents www.kansasregents.org/financial_aid/awards.html
Washburn University www.washburn.edu/financial-aid/scholsearch.html
University of Kansas Medical Center www.kumc.edu/studentcenter/financialaid.html

Most accredited schools of nursing in Kansas have resources for financial aid for new or continuing students. A complete Kansas State Board of Nursing (KSBN) list of currently accredited four year and two year schools of nursing, as well as a list of accredited ARNP programs and contact information can be viewed, downloaded and printed at
www.ksbn.org/cne/nursingschoolst.pdf

Continuing Education

Thirty (30) contact hours of approved continuing nursing education credit are required for RN license renewal every two years in Kansas. Information about continuing education requirements can be accessed at www.ksbn.org/cne/cne.htm

The Annual Kansas School Nurse Conference offers 15 CNE hours through WSU, however you must be present for the entire conference. Partial credits are not available for specific sessions. Attending the conference each year will allow you to meet the CNE requirements for licensure.

The Internet is a vast resource for Continuing Education offerings. You can choose nearly any search engine and type in 'Continuing Nursing Education' and be directed to literally hundreds of offerings. Announcements of other CNE offerings relevant to school nurses and contact information will be posted as they become available and updated continuously on
www.kdhe.state.ks.us/bcyf/c-f/zips/index.html

Online CNE calendars are available at the following sites:
The Kansas Continuous Learning Project www2.kumc.edu/kclp/courses.html
Pittsburg Center online CE Virtual Classroom www.kumc.edu/vc/
Washburn University www.washburn.edu/ce/
Pittsburg State University Department of Nursing www.pittstate.edu/nurs/cne.htm
University of Kansas Medical Center www.kuce.org/kumc/

School Health Services Contract Information

School districts must comply with Individuals with Disabilities Education Act (IDEA) and its regulations. School districts may also offer health services to all students, whether disabled or not, and if these services are to be provided under a contractual agreement, that agreement should be carefully thought out and written with specificity. Public schools must provide mandated health screenings consisting of vision, hearing, and dental screens referred to in KSA 72-5205, KSA 72-1205, and KSA 72-5201. Also children entering school must provide evidence of immunization and the results of a physical health assessment prior to admission to and attendance of school under KSA 72-5209 and K.A.R. 28-1-20, and KSA 72-5214. Any existing contracts should be reviewed to ensure that the understandings and expectations of the parties are clearly specified.

School districts should also become familiar with the "Delegation and Supervision of Specific Nursing Tasks in the School Setting" as specified in regulations of the Kansas State Board of Nursing found at:

http://www.ksbn.org/npa/pages/60-15-101.doc

http://www.ksbn.org/npa/pages/60-15-102.doc

http://www.ksbn.org/npa/pages/60-15-103.doc

http://www.ksbn.org/npa/pages/60-15-104.doc

Specifically, these regulations apply to any nursing services provided for any students during the school day.

An informational document was created through input and collaboration from KDHE Child & School Health Consultant, legal counsel from the Kansas State Department of Education, and legal counsel from the Kansas State Board of Nursing and the Kansas State Nurses Association, to provide clarification and guidance regarding contacts for "school nurse services". A copy of this letter, including a sample contract, can be viewed and downloaded by visiting the KDHE School Health Resources page, and clicking on "Forms/Letters" by visiting: http://www.kdhe.state.ks.us/c-f/school.html

NANDA, NIC and NOC

Because school nurses practice in isolation in a non-health care setting, their position can be particularly ambiguous in terms of both role and identity. Nursing in general, and school nursing in particular has tended to organize and describe itself in terms of medical problems, diagnoses and diseases rather than in terms of positive client outcomes, making it hard to recognize the impact of specific nursing interventions on those outcomes. If students are successful in school--particularly students with special health care needs—the school nurse role may well be invisible. When those contributions go uncategorized and therefore unrecognized, nurses are unable to have a significant impact on decisions affecting health policy which in turn drive funding decisions.

Standardized nursing terminologies were developed to improve the quality of nursing care as well as the visibility of nursing by documenting reliable information about nursing practice. The North American Nursing Diagnosis Association (NANDA) introduced the first diagnostic classification in 1973 to categorize clinical nursing judgments about responses of individuals, families or communities to actual or potential life processes and health problems. In 1989 the American Nurses Association (ANA) designated NANDA as the organization to develop an official nursing diagnosis classification system.

In 1987, the Center for Nursing Classification at the University of Iowa College of Nursing introduced the Nursing Interventions Classification (NIC) and in 1991 the Nursing Outcomes Classification (NOC). These two additional classifications were developed for use with NANDA and other diagnostic systems

NIC is a kind of glossary of treatments that nurses perform in all settings and specialties. A nursing intervention is "any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance client outcomes" (McCloskey & Bulechek, 2000). NIC interventions can include both the physiological (like tube feeding or medication administration) and the psychosocial (i.e. anxiety reduction, smoking cessation assistance, etc). There are interventions for **illness treatment** (hyperglycemia, seizure management, etc), **illness prevention** (injury prevention, risk identification, etc) and **health promotion** (exercise promotion, normalization promotion). Interventions can be for families and communities (family integrity promotion, environmental management) or for individuals.

NOC is a collection of terms to define "client status following nursing interventions." (Johnson & Maas, 2000), or outcomes. These outcomes were identified to measure or quantify the effects of nursing interventions and can be used in all settings (including schools) and with all client populations (including students). Standardized outcomes are designed for use across the care continuum and so can measure client status through various health events over extended periods of care. There are seven NOC domains, which describe the desired client response: Functional Health, Physiologic Health, Psychosocial Health, Health Knowledge and Behavior, Perceived Health, Family Health, and Community Health.

Computerized nursing information systems are increasingly being used for documentation across all health care settings. Their eventual dominance over paper records has generally come to be recognized as an inevitable circumstance, creating a necessity for standardized nursing languages. Unified medical and nursing language systems (UMLS, UMNS) are already being developed in order to facilitate the comparison of data among health care systems and providers. NANDA, NIC and NOC have already been approved by the American Nurses Association for inclusion in the unified nursing language system and studies have demonstrated the relevance of these language systems/taxonomies to the school nurse setting.

NIC and NOC are a very new concept to most school nurses, though they are being increasingly utilized in traditional health care settings

School nurses sometimes find it difficult and time consuming to use nursing diagnoses in the school setting. It should always be remembered that *nursing diagnosis is the recommended form of communication in nursing*, and school nurses do not cease to function as nurses simply because they function in a non-health care setting.

In the school setting, it becomes even more imperative that nurses utilize the language of nursing diagnoses to provide:

- A system of uniform terminology for school nurse practice, education and research.
- An ability to distinguish the focus of the school health nurse from other professionals in the setting
- A clear direction for intervention, especially for the school nurse with a high nurse-to-student ratio, by focusing on a specific problem rather than general ones
- A standardized language which can be adapted to technology
- A method to clarify and validate the role and focus of the school health nurse for students, teachers, administration, families, and the community
- Effective communication with other disciplines

By using NANDA, NIC and NOC in the school setting, school nurses will:

- Support continuity of care for children, families and the school community
- Help to describe the complexity of student, family and school community responses to illness, injury and wellness
- Describe the intricacy and complexity of school nursing treatments
- Help to describe the effectiveness of school nursing treatments
- Assist with the efficient and comprehensive documentation
- Create a uniform terminology to facilitate data collection as well as precise and comprehensive communication with others about school nursing practice, education and research
- Promote the development of school nursing knowledge
- Create a mechanism for the evaluation of school nursing and evidence based practice
- Help to distinguish the practice of school nurses from other professionals in the school setting
- Prepare school nurses for the inevitable and impending electronic patient record that is anticipated to become the norm in the near future

Because there is currently no state sanctioned standardized software for school nursing, it is important that school nurses ensure that NANDA, NIC and NOC are included in school health office software purchases in order to promote quality nursing care for students, validate school nursing interventions, and promote research at the local, state and national level to promulgate the school nurse role.

The NANDA website and publications (including Nursing Diagnoses: Definitions and Classifications 2001-2002) can be viewed at www.nanda.org/

The NASN position statement on NANDA, NIC and NOC can be found at www.nasn.org/positions/nanda.htm

The Center for Nursing Classification (NIC/NOC Newsletter) can be accessed at http://www.nursing.uiowa.edu/centers/cncce/

The Nursing Minimum Data Set NMDS

Electronic storage of student health records is quickly becoming the norm in Kansas and across the country. Neither KDHE or KDOE at this time mandate any specific records system, electronic or otherwise, but believe it is incumbent upon us to provide direction for the use of common terms to store, retrieve, analyze and communicate the elements of school nursing in student health databases. Including school nursing data in district, state, and eventually national education and health care databases will provide the means to measure the effectiveness and value of the provision of health services in schools.

Storing data in electronic or digital form is an extremely efficient method of storing, retrieving and analyzing data for student populations. Electronic records have the capacity to turn isolated pieces of data into information and knowledge with the potential to greatly enhance the quality of nursing care for students and the school community. As budgets become tighter and school reform focuses more and more on educational outcomes alone, it is absolutely essential that school nurses be able to measure their contribution to student outcomes in terms of both health and education in order to meet student, family, and faculty needs.

The use of computers to store student health records is one very important and efficient way that local school districts can consistently and accurately document, compile, retrieve, aggregate and analyze data regarding student health status, however it requires that school nurses agree upon the terms to record data. In order to compile, aggregate, and retrieve school nursing care data, the fields used and data elements must be the same between and within student health record databases. While this may be quite manageable within school districts—particularly smaller districts that use a single canned program for all students, it becomes more challenging when different schools and school districts use different programs. The KDHE School Health Program supports the collection of the **Nursing Minimal Data Set** (NMDS) as *essential nursing data* that needs to be collected across all health care settings, including schools.

The use of a common vocabulary among nurses in schools and nurses in other settings allows comparisons of nursing care across populations, settings, and regions over time. **The Nursing Minimum Data Set** (NMDS) provides a framework for electronic data sets to support nursing care in any setting. The NMDS is similar to other health care data sets in medical informatics except that it includes four nursing care elements and a unique provider number for each registered nurse. The sixteen elements of the NMDS are divided into three categories: **Nursing Care Elements** (nursing diagnosis, nursing intervention, nursing outcomes, nursing intensity) **Client Elements** (unique individual identifier number, date of birth, gender, race and ethnicity, and **Service Provider Elements** (unique facility number, unique health record number, unique registered nurse provider number, encounter date, discharge date, disposition of client, and expected payer of bill.) While it is not reasonable to assume that a data field such as “discharge date” would consistently be used in the school setting (except possibly as the date a student leaves the system), the other fields are all well within the practice setting of the school nurse. If you have worked recently in a health department, physician office, hospital or long term care facility, you will recognize most of these data fields as essential elements already incorporated into electronic records.

School nurses in Kansas must make a commitment to the utilization and clarification of terms currently within the Nursing Classification Systems (NANDA, NIC, NOC) and the Nursing Minimal Data Set, which can then be developed and refined to more adequately reflect the delivery of nursing care in the school setting. In order to legitimately negotiate to receive third party reimbursement for services, school nurses must also recognize that they are subject to the Administrative Simplification (AS) provisions of HIPAA, the Health Insurance Portability and Accountability Act. The intent of HIPAA is to decrease the cost and burdens associated with health care transactions with standard electronic transmission of administrative and financial information. Any forms, databases, electronic records or flow sheets being developed or considered for use in the school setting should include fields for the elements of the NMDS, with the possible exception of the discharge date.

The School Health Program at KDHE recognizes and promotes the teaching and implementation of standardized nursing vocabulary (NANDA, NIC, NOC) and the Nursing Minimal Data Set as recognized by the ANA. We support the testing and implementation of standardized nursing vocabulary and data field elements in the school practice setting and will encourage and support collaboration with developers of standardized nursing classifications and the NMDS in order to integrate them into school nursing practice statewide.

The NASN position statement on the Nursing Minimal Data Set for School Nurses can be found at http://www.nasn.org/positions/2004psnursingminimum.pdf

Bright Futures

Bright Futures is a vision, a philosophy, a set of expert guidelines, and a practical developmental approach to providing health supervision for children and adolescents from birth through age 21. Bright Futures is dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice. Its mission is to promote and improve the health, education, and well-being of infants, children, adolescents, families, and communities.

Bright Futures was initiated in 1990 and guided by the Health Resources and Services Administration's Maternal and Child Health Bureau, with additional program support from the Health Care Financing Administration's Medicaid Bureau. Comprehensive health supervision guidelines were developed with the collaboration of four interdisciplinary panels of experts in infant, child, and adolescent health. The final draft was reviewed by nearly 1,000 health professionals, educators, and child health advocates throughout the United States and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* was published in 1994. In 1995, an effort was launched to implement the Bright Futures guidelines by publishing practical tools and materials and providing technical assistance and training. The guidelines were updated for publication in 2000 to incorporate current scientific knowledge in health practice.

For each of the 29 recommended health visits (newborn through 21), the guidelines provide key health questions, developmental observations or milestones, scheduled immunizations and screening procedures, and specific guidance for families on anticipated changes their child will experience in the approaching stage of development. *While it is not anticipated that nurses working in and with schools will be the primary provider for most of these visits (with the possible exception of EPSDT screens), the developmental approach of Bright Futures is extremely user friendly and essential for nurses who may have daily encounters with infants, children and adolescents through the school setting.* Appendices cover the spectrum of screening and developmental concerns ranging from hearing to hypertension, from measurement of growth and body-mass-index to the stages of sexual development. **Many of these appendices are not available on the web, and must be obtained from the hard copy of the guidelines, which can be ordered from the Bright Futures site: www.brightfutures.org**

Based on extensive review of scientific literature and best practices, the Bright Futures guidelines were developed by multidisciplinary expert panels and reviewed by nearly 1,000 practitioners, educators, and health advocates. The guidelines are consistent with those of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry, and were developed with the support of the Health Resources and Services Administration's Maternal and Child Health Bureau

KDHE-BCYF Children and Families adopted Bright Futures as the Kansas guidelines and standards for health supervision of infants, children and adolescents by all public health nurse providers in 2002. All health departments received a copy of the original Bright Futures Guidelines, and the Children, Youth and Families Health Services Manuals Volumes I and II were replaced by this Planning and Resource Guide and the Bright Futures Guidelines for Health Supervision, Nutrition, Oral Health, Mental Health and Physical Activity in 2002. Because the materials and links are available on the web and are updated regularly, it is anticipated that Bright Futures will serve as a much more cost effective, reliable, comprehensive and current resource than anything KDHE-BCYF could publish or disseminate in a timely manner.

In addition to the basic guideline series for Health Supervision, Nutrition, Oral Health, Mental Health and Physical Activity, Bright Futures has a plethora of support materials available to be downloaded and printed or ordered, including Family Tip Sheets, an Activity Book for children, Encounter Forms for Families, Nutrition Family Fact Sheets, a Health Record and a Family Pocket Guide. Many materials are available in both Spanish and English. Materials can be ordered as well as downloaded from the Bright Futures website at www.brightfutures.org.

All of the Bright Futures materials make excellent professional development resources and references for direct service providers, and are extremely user friendly for developing in-service presentations for licensed and unlicensed personnel since they are organized from a developmental perspective.

NCEMCH (National Center for Education in Maternal Child Health) also produces a series of knowledge paths on MCH-related topics and can be found at: http://www.mchlibrary.info/KnowledgePaths/index.html. These knowledge paths contain selections of up-to-date, high-quality resources and tools for staying abreast of new developments and conducting further research. Components of a knowledge path include links to Web sites, electronic publications, databases, discussion groups, and citations for journal articles and other print resources.

NCEMCH's knowledge paths on maternal and child health-related topics contain selections of recent, high quality resources and tools for staying abreast of new developments and conducting further research. Components of a knowledge path include links to Web sites, electronic publications, databases, and discussion groups, and citations for journal articles and other print resources.

Current knowledge paths include:

Adolescent Pregnancy Prevention (July 2004)

Adolescent Violence Prevention (March 2004)

Asthma in Children and Adolescents (April 2004)

Child and Adolescent Health Insurance and Access to Care (December 2003)

Child and Adolescent Nutrition (March 2005)

Children and Adolescents with Special Health Care Needs (May 2003)

Diabetes in Children and Adolescents (November 2003)

Domestic Violence (December 2002)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (July 2003)

Infant Mortality (September 2003)

Mental Health in Children and Adolescents (May 2004)

Oral Health and Children and Adolescents (January 2005)

Overweight in Children and Adolescents (November 2002)

Physical Activity and Children and Adolescents (September 2003)

Postpartum Depression (December 2002)

Preconception and Pregnancy (February 2005)

Racial and Ethnic Disparities in Health (December 2002)

Spanish-Language Health Resources | En Español (March 2003)

The following criteria are used for evaluating resources and selecting items for the knowledge path so that you can be assured the information you are accessing is reliable and current:

- Accuracy - Information contained in the knowledge path selections must be accurate, verifiable, and peer reviewed.
- Authority - Selections must be from an authoritative source.
- Objectivity - Selections must be educational in nature and not for the purpose of making a profit. Selections must meet the information needs of the audience for whom the knowledge path is intended.
- Currency - Selections must be very recent (publications written in the last 2 years or Web sites that are frequently updated); an older item may be considered if it sets the foundation for future research (e.g., a Surgeon General's report).
- Coverage - Selections must specifically address the knowledge path topic. Resources must be public health oriented and not clinical in nature. Resources that describe and/or evaluate programs and/or discuss "lessons learned" are particularly helpful to the MCH community and are often added to the paths.
- Access - Web sites and other electronic resource selections must be easily accessible and navigable. If not and the selection is essential to the path, NCEMCH will add navigational tips for the user.

Bright Futures Children's Health Charter

Principles developed by advocates for children have been the foundation for initiatives to improve children's lives. Bright Futures participants have adopted these principles in order to guide their work and meet the unique needs of children and families in the 21st century.

- Every child deserves to be born well, to be physically fit, and to achieve self-responsibility for good health habits.

- Every child and adolescent deserves ready access to coordinated and comprehensive preventive, health-promoting, therapeutic, and rehabilitative medical, mental health, and oral health care. Such care is best provided through a continuing relationship with a primary health professional or team, and ready access to secondary and tertiary levels of care.

- Every child and adolescent deserves a nurturing family and supportive relationships with other significant persons who provide security, positive role models, warmth, love, and unconditional acceptance. A child's health begins with the health of his parents.

- Every child and adolescent deserves to grow and develop in a physically and psychologically safe home and school environment free of undue risk of injury, abuse, violence, or exposure to environmental toxins.

- Every child and adolescent deserves satisfactory housing, good nutrition, a quality education, an adequate family income, a supportive social network, and access to community resources.

- Every child deserves quality child care when her parents are working outside the home.

- Every child and adolescent deserves the opportunity to develop ways to cope with stressful life experiences.

- Every child and adolescent deserves the opportunity to be prepared for parenthood.

- Every child and adolescent deserves the opportunity to develop positive values and become a responsible citizen in his community.

- Every child and adolescent deserves to experience joy, have high self-esteem, have friends, acquire a sense of efficacy, and believe that she can succeed in life. She should help the next generation develop the motivation and habits necessary for similar achievement.

Population Based Mandated Screening Records and Reporting

Kansas' statutes currently mandate four educational screenings for preschool and school age children in Kansas' schools. These statutes apply to all Kansas schools and are part of the educational record. Mass screening records have no special requirements regarding confidentiality, and may be collected, compiled, recorded and disseminated by unlicensed school personnel. These mandated screenings include vision, hearing, dental and immunizations. Other than immunizations, Kansas' statute currently includes no mandated reporting to the State Department of Health or any other agency concerning aggregate data for these screening activities.

One additional screening statute, Child Health Assessment at School Entry (CHASE) 72-5214, does contain statutory language relating to confidentiality, and will be discussed more extensively in the next section.

Because the language of the statutes is subject to change, it is recommended that school nurses review the most current version of the following statutes available at http://www.kslegislature.org/legsrv-legisportal/index.do each school year to be certain they are referencing current information in district policy. Any changes will be denoted by a recent date at the bottom of the statute i.e. July, 2001. By plugging the appropriate statute number in the "Quick Search" box to the right of the screen (Find A Statute, Enter A Statute Number), users can link directly to the most current version of the statute and print hard copies if desired. Information can also be stored electronically on your hard drive or on a disc or CD. The following statutes reference school screening mandates that are part of the educational record: **72-5201 through 72-5203** (Dental), **72-5204 through 72-5205** (Vision), **72-5208 through 72-5211**, including **72-5211 a** (Immunizations), and **72-1204** through **72-1207** (Hearing).

Screening in Kansas Schools

School and health department nurses in Kansas have traditionally been very involved in the provision of mandated screening services. It is the position of KDHE, Children and Families Section that school nurses, because of their education and training, are in an excellent position to coordinate and manage school screening programs. Registered professional school nurses have the educational preparation and professional expertise to train and supervise paraprofessionals and other UAPs to conduct hearing, vision, and oral health screening in schools and health departments. Accurate and meaningful screening is essential if school nurses are to collaborate in an effective manner with local primary care providers and specialists for referral and follow up of identified problems.

Nurses working in and with schools know that hearing and vision problems occur at higher rates among students with learning disabilities and developmental problems, and that oral health and compromised immunization status may occur more frequently among those at risk for poverty. These nurses are in a unique position to ensure the provision of appropriate referrals and follow up treatment to ensure continuity and quality of care.

Be aware that the practice of initial mass screening of large populations by school nurses may be difficult to defend as a cost effective or efficacious utilization of registered professional nurse time. The referral process and follow up, however are decidedly well within the purview of the school nurse, as are screenings that are done as a component of a total comprehensive student health assessment such as KBH or CHASE. All of the mandated screenings can be provided as part of a comprehensive health assessment for students by utilizing registered professional nurses to provide the Child Health Assessment at School Entry or Kan Be Healthy assessment for Medicaid eligible students. These are reimbursable services, as opposed to the mass screening, which has no money attached.

Any KBH or CHASE screening done by a registered professional nurse should be done in partnership with a medical home and a primary care provider (PCP) for quality and continuity of care as well as to

create a reimbursement mechanism. ***Only mandated screening results (vision, hearing, dental, immunization status) should be recorded in the educational record.*** *The comprehensive nature of the KBH and CHASE assessment necessitates the maintenance of a separate confidential health record in the school setting if records are to be maintained at the school site.*

Mass school screenings are by nature conducted in complete isolation from the student's medical home, creating a very real problem in terms of an effective referral mechanism for students who do not pass a screen. **Students who do not pass screenings have been done a great disservice if a methodology for referral and follow up is not in place at the time of the screening.** It is the recommendation of KDHE, Children and Families Section that school nurses coordinating and managing screening programs develop a partnership with parents, the medical home, and specialists in or near the community, as well as payer sources to ensure that students who do not pass school screens have access to a medical home or a specialist for expedient diagnosis and treatment by the appropriate medical professional. **This may mean taking an active role in assisting parents to complete a HealthWave application, to navigate the health care payer system, and/or to access appropriate providers.** Periodic isolated screening in and of itself cannot even begin to adequately address either the educational or health needs of students. To justify the investment in time, personnel, and resources, school-screening programs must be a part of a coordinated, integrated health services program

Students who are already being treated/followed by a medical professional for a problem which mass screening is designed to identify should not continue to be unnecessarily screened and referred. To do so creates and perpetuates a credibility gap between the medical home and the professional school nurse. In addition, screening for an obvious problem can create unnecessary and counterproductive delays in access to care. In particular, children with **known** hearing or vision related special health care needs should have yearly follow up by a PCP or subspecialist. Diagnostic screening information concerning the current status and treatment of hearing or vision needs must come from the HCP. School screening programs are not diagnostic in nature and cannot provide the information necessary for IEP or IFSP teams to make educational decisions regarding level of placement or specific services. **Communication with health professionals regarding current health status and recommendations is essential to a student's educational progress and is a standard of professional school nurse practice.** Documentation of current treatment and HCP recommendations must be a part of the student's educational record.

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KDHE, Children and Families Section, has adopted the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents as the Kansas Standard for provision of all child and adolescent health services for all nurse and physician providers. www.brightfutures.org/**. These guidelines contain some information regarding specific mechanisms for screening, however KDHE Children and Families encourages nurses working in and with schools to carefully examine and utilize as appropriate developing new technologies to improve the efficiency, efficacy and accuracy of mass screenings as they develop screening programs.**

School Nurse Survey

There is no mandated reporting to the Kansas Department of Health and Environment or the Kansas Department of Education of school screening results, however, the Kansas Department of Health and Environment, Children & Families Section, has created a web-based School Nurse Survey that

provides a mechanism to review and aggregate data for school districts in Kansas related to school health service needs and provided services. School nurses and school administrators can access this survey at:
http://public1.kdhe.state.ks.us/School%20Nurse/School%20Nurse.nsf/SchoolDemographics?OpenForm.
Data will be compiled yearly and made available through the KDHE website. Reports can be completed online at: http://www.kdhe.state.ks.us/c-f/school.html
or mailed to:
Child and School Health Consultants
Kansas Department of Health and Environment
1000 SW Jackson, Suite 220
Topeka, KS 66612
Phone: 785.296.7433 or 785-296-1308
Fax: 785.296.4166
mailto:jstueve@kdhe.state.ks.us

School Dental, Vision, Hearing, and Scoliosis Screening Programs

72-5201 through 72-5203 www.kslegislature.org/cgi-bin/index.cgi Free dental inspection is required annually for all children attending school, ***unless the student has a certificate from a legally qualified dentist indicating that examination has been made within the last three months***. School districts are required to provide a place for inspection and designate a competent, licensed dentist or dentists to make assessments. A certificate of inspection is to be kept on file and one sent home with the student with suggestions of requirements for the curing of any defects found. No dental work may be done without the consent of the parents or guardian of the student.

*The lack of dental providers in Kansas has created a real life situation in which this statute is extremely difficult to implement. It is listed here because it **is** listed in statute and has been since 1923. School districts are encouraged to have a policy in place by which they meet the intent, if not the letter of the law.*

72-5204 through 72-5205 www.kslegislature.org/cgi-bin/index.cgi Basic vision screening is mandated for every student at school entry and at least every two years thereafter. ***The law does not apply to students who have had a basic vision screening in the six months prior to basic vision screening in the school.*** This statute states that basic vision screening is to be done by a teacher or some other person designated by the school board. The results of the test and, if necessary, the desirability of examination by a qualified physician, ophthalmologist or optometrist must be reported to the parents or guardians of pupils. Information relating to the desirability of examination by a qualified physician, ophthalmologist or optometrist may not show preference in favor of any such professional person. Schools are also required to encourage any student having difficulty mastering basic reading, writing or math to seek a professional eye exam at parental expense if public or private insurance coverage is unavailable.

Kansas Department of Health & Environment, Bureau for Children, Youth & Families **Vision Screening Guidelines For Infants, Toddlers, Children and Youth** should be utilized for all age children and youth (birth to 21 years) in child health programs including EPSDT (KAN Be Healthy) screening, well-child screening, Part C early intervention screening and school screening. They are designed to be used in conjunction with child health standards of care. These guidelines can be viewed and downloaded at: http://www.kdhe.state.ks.us/bcyf/download/VisionGuidelines2004.pdf

Another vision screening resource is available at www.aafp.org/afp/980901ap/broderic.html . This is an American Academy of Family Physicians site with information very similar in content to what has been previously published as Vision Screening Guidelines by the Kansas Department of Health and

Environment and the Kansas Department of Education. For those involved with Child Find and infant/toddler programs, the site includes the AAP recommendations for infant and toddler screening consistent with the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

72-1204 through 72-1207 www.kslegislature.org/cgi-bin/index.cgi Basic hearing screening is required for all new students and at least once every three years thereafter. Statute dictates that all tests shall be performed by a person competent in the use of a calibrated audiometer and who has been designated by the board of education which provides the basic hearing screening. Educational audiologists in Kansas have compiled a protocol for hearing screening in schools utilizing nonprofessional certified hearing screening technicians. School boards may reference these guidelines when making decisions as to how to best provide hearing screenings in their districts. http://www.kansped.org/ksde/resources/hearingguide.pdf

Registered Professional School Nurses are exempted from the regulations regarding Certification of Hearing Screening Technicians and Assistants. KSA 65-1113 www.ksbn.org/npa/npa.doc (pg. 15), not KAR 28-61-8, defines the scope of practice for RNs. The definition in KSA 65-1113(d) includes executing the regimen of a person licensed to practice medicine. Registered professional nurses by training, experience and licensure, assist in identifying and assessing child health concerns, including hearing, vision, and oral health. Any abnormalities must of course be referred to the primary care provider of record for diagnosis and treatment. Kansas Health Occupations Credentialing, which governs the practice of audiologists in Kansas, has no interest in dictating the scope of practice of registered professional nurses. Nothing in statute or regulations requires that professional nurses be certified as hearing screening technicians to provide or supervise hearing screening programs in schools, however it is incumbent upon the nurse to ensure that he/she is competent in the use of the equipment used for screening.

State categorical aid for school districts will **not** be withheld if the school nurse is not certified as a hearing screening assistant supervised by an audiologist. School nurses and Speech Language Pathologists are specifically exempted from this provision in the **Special Education Reimbursement Guide** (Hearing Screening Technicians/Audiology Assistants pg.24, revised 12/18/01). **Paraeducators** providing hearing screening in the school setting **for students with IEPs** and working directly with an educational audiologist as a hearing screening technician or audiology assistant must be certified as hearing screening technicians in order to ensure that the state categorical aid for the provision of hearing screening for students with IEPs screened by the para remains intact.

Immunization Screening and Audits

72-5208 through 72-5211 and 72-5211a www.kslegislature.org/cgi-bin/index.cgi or www.kdhe.state.ks.us/immunize/imm_manual_pdf/index.html Section F. All students enrolling in schools must provide proof of compliance with immunization requirements. Students may be excluded for failure to comply with immunization requirements. The Immunization Section at KDHE will send out information to every school district when requirements change or are temporarily waived.

The Kansas Immunization Program is coordinating a Kansas Immunization Registry which will allow access to immunization records for school nurses and other health care providers across the state, enhancing the efficiency of record keeping and tracking of immunization history of Kansas children.

Kansas Certificate of Immunization

Current immunization requirements are listed on the Kansas Certificate of Immunization Form (KCI) available at www.kdhe.state.ks.us/immunize/resources.html or http://www.kdhe.state.ks.us/c-f/school_resources_links.html. During the 2004 Kansas Legislative Session a regulatory change in the school age immunization requirements K.A.R. 28-1-20, which can be found at the Kansas Immunization Program website at: http://www.kdhe.state.ks.us/chickenpox/download/kar_28_1_20.pdf to include immunizations for Hepatitis B and Varicella (chickenpox) for Kindergarten entry. The 2005-2006 school year will include all Kindergarten entry and 1st grade students.

Currently, the KCI form is required for audit documentation. Information may be transcribed from other sources on to the KCI, but the transcriber must certify the accuracy of the information with signature and title.

An Immunization Audit letter and reporting form is mailed to each school building at the beginning of the school year and is usually due to Immunizations by the first of December. This audit is the method of data collection for the Kansas Two Year Old Retrospective Immunization Study. If you have questions about audit completion, or if you would like for your Immunizations Field Representative to assist with your audit, you may access the Immunization Field Staff directory at http://www.kdhe.state.ks.us/immunize/index.html

Contact Martha Siemson, RN msiemson@kdh.state.ks.us (785) 296-2774 with questions or concerns.

Scoliosis/Postural Screening

Postural screening consists of screening for scoliosis and kyphosis. While only four percent of young people 10 to 14 years of age have some signs of scoliosis, it is advisable to screen annually from ages 10 through 15. Early identification enables early treatment and the prevention of severe deformity.

The purpose of this screening program is early identification of spinal deformities so that treatment can be initiated to prevent, if possible, the need for surgery and the discomfort and complications that occur with these deformities.

Effective implementation of a postural screening program involves collaborative effort and support among screeners, school personnel, the medical community, parents and students. To ensure success all involved must understand the purpose of this screening program.

Postural screening is not a mandated screening in Kansas.

For more information on scoliosis/postural screening programs in schools visit:
http://www.aaos.org/wordhtml/papers/position/1122.htm
http://www.aafp.org/afp/20000701/putting.html

Child Abuse Neglect
(Refer to the complete statutes for full definition of the law

38-1521 through 38-1524 www.kslegislature.org/cgi-bin/statutes/index.cgi Educational and health care staff at schools shall report promptly when reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse. The report may be made orally and shall be followed by a written report if requested.

Willful and knowing failure to make a report required by this section is a class B misdemeanor. Preventing or interfering with, with the intent to prevent, the making of a report required by this section is a class B misdemeanor.

Reports made shall be made to the state department of social and rehabilitation services (SRS) at 1-800-922-5330. When the department is not open for business, the reports shall be made to the appropriate law enforcement agency. Reports of child abuse or neglect occurring in an institution operated by the secretary of social and rehabilitation services or the commissioner of juvenile justice shall be made to the attorney general.

Elementary and secondary schools, the state department of social and rehabilitation services and law enforcement agencies shall cooperate with each other in the investigation of reports of suspected child abuse or neglect. Administrators of elementary and secondary schools shall provide to employees of the state department of social and rehabilitation services and law enforcement agencies access to a child in a setting on school premises determined by school personnel for the purpose of the investigation of a report of suspected child abuse or neglect.

Guidelines for Management of Child Abuse and Neglect

*Refer to the State of Kansas Statutes.

*Refer to local written school policy.

*Refer to the publication entitled “A Guide to Reporting Child Abuse and Neglect in Kansas” that is available through the Kansas Children’s Service League at http://www.kcsl.org/ of call:
316-942-4261.

Expanded School Health Services

For most of the last century, school health programs in Kansas were structured to provide basic population based child health services including

- Hearing and vision screening
- Emergency care or first aid
- K-12 health education, and
- Maintenance of a safe and healthy school environment

In the 21st century, much has changed in child health care, including:

- Newborn hearing screening mandates at the state level
- The reauthorization of IDEA in 1997 with a renewed emphasis on LRE (least restrictive environment) coupled with an influx of children with severe physical and mental health care needs into the schools as state facilities closed or were downsized
- The emergence of Managed Care as the predominant form of health services provision, and the concept of a medical home for every infant, child and adolescent
- Authorization of the Children's Health Insurance Program (CHIP) to make no cost or low cost insurance coverage available for all infants, children and adolescents
- The No Child Left Behind Education Act of 2001, the most sweeping educational reform of the last 75 years

As discussed in previous sections, these changes have necessitated a new look at which health services are provided in schools and how they are provided. While it would be nice to sit back and say with conviction that nothing has really changed, that the pendulum always swings back and forth, that schools still need the same services they've always needed—it just isn't true. Things have changed, drastically. Health care providers working with schools may have to bring schools up to speed on what exactly those changes entail for the children and adolescents they currently serve, as well as the infants they will be serving in the future.

At the same time, public schools find themselves accountable in a way they have never before encountered for student academic achievement and success. Their very existence depends upon it. As state funds are cut back as a result of the recession stemming from 9/11, new federal initiatives threaten further cuts for the most vulnerable schools and student populations. It is not the intention to argue for or against private school vouchers, public, or charter schools, but reality requires that nurses and physicians working in and with schools understand the economic realities of education funding and why it may no longer be reasonable to assume that school health services will continue to be funded entirely through an educational funding stream in Kansas or anywhere else.

There are ways to help support the financial burden of school health services through *health care* funding streams—one of which is to look at reducing or eliminating traditional school health services and replacing them with the kinds of expanded school health services outlined below.

Engaging in the kind of thought processes required to honestly examine past and future practice of school health services is difficult and sometimes painful. It is hard to let go of traditional ways of doing things, and even harder to think in new ways. There are no easy answers. For example:

- With mandated newborn hearing screening, how necessary is it to continue to provide mass hearing screening in the school setting after an initial school screen? What is the actual intervention (once a referral is made) for those who do not pass screens? Is it educationally or medically significant intervention? If not, why do we continue to screen?
- From a health care perspective, does it make sense to continue to screen children and adolescents with known hearing and vision losses/impairments? Would it make more economic and educational sense to refer students with known losses/impairments annually to the PCP of record, audiologist or optometrist/ophthalmologist, follow up on the referral, and communicate/interpret results to team members at the school site?

- Mass hearing screening is fairly effective at random otitis media detection. With the new pediatric protocols for treatment of OM, does it make sense from a health care perspective to continue mass screening to identify and refer it? Does it make sense from an educational perspective to send these kids to the Dr. who may not even see them unless complications develop?
- Would it make more sense from a health care perspective to mass screen students for a medical home and insurance to ensure provision of health care when necessary rather than for hearing or vision problems that may be readily apparent without screening?

Explore some of the possibilities listed below and work hard to think of every service in terms of a partnership with primary care providers and a payer source. As we start to think in those terms, new possibilities and new opportunities for new ways to provide new health services (and update provision of some of the old ones) will come to light.

Child Health Assessment at School Entry (CHASE)

KSA 72-5214 www.kslegislature.org/cgi-bin/index.cgi. This statute requires that any student new to Kansas schools up to age nine must provide the school with the results of a health assessment conducted within the last 12 months by a public health nurse, by a physician or by a person acting under the direction of a physician.

Schools may exclude students who are noncompliant. The only alternatives to CHASE are written parental notification that the child is an adherent of a religious denomination whose teachings are opposed to such assessments or a written statement that the assessment has been or will be scheduled for completion within 90 days.

Schools must provide parents information regarding CHASE prior to the commencement of the school year and they must transfer CHASE information just as they do immunization information if a student moves.

KSA 72-5214 specifically states that "…Information contained in the health assessment shall be confidential and shall not be disclosed or made public beyond that necessary…", implying that the information contained in the health assessment may have some state safeguards beyond FERPA. *Information contained in the CHASE assessment should not be analyzed or interpreted by anyone other the registered professional school nurse or physician, and should never be disseminated to non-medical personnel without express written parental permission*. Physician providers outside the school may cease to provide adequate identifiable health information necessary for health providers at school if there is a concern that doing so may place the provider out of compliance with HIPAA regulations, as these regulations enforced by the office of civil rights carry steep fines (up to $500,000 per violation). aspe.hhs.gov/admnsimp/ and www.ehcca.com/presentations/HIPAA2/302b.PDF

*Nurses who have completed the **KBH Training** through SRS-Medicaid to provide EPSDT screens are also able to perform and be reimbursed for CHASE, WIC assessments, and other child health assessments. It is essential that CHASE assessments be conducted in partnership with PCP network for referral purposes, as well as to ensure continuity and quality of care and a medical home for every infant, child and adolescent. It is expected that children for whom the CHASE assessment is provided will be enrolled in a health insurance program, FQHC or RHC and connected with a primary care provider for a medical home.*

Children With Special Health Care Needs (CSHCN)

Essential information for nurses practicing in schools regarding IDEA and 504 is: Schwab, N & M. Gelfman (Eds.) (2001). Legal issues in school health services: A resource for school nurses, administrators and attorneys. North Branch, MN: Sunrise River Press. 1-800-895-4585 www.schoolnursebooks.com/

Advances in medical technology and progressive legislation have resulted in an increased number of students with special health care needs attending schools and child care programs. Some students have technology related needs (mechanical ventilation, tracheostomies, oxygen, gastrostomy buttons, etc) supplemental nutrition needs, medications or other special health care needs which must be addressed during the school day to allow them to benefit from the educational process. A far greater number have chronic health conditions such as diabetes, asthma, anemia, hemophilia, seizure disorders, urea cycle disorders, or blood dyscrasias. Some conditions require daily management while others may require only intermittent management or the provision of acute care procedures for exacerbation in the school setting.

Individualized Health Care Plans are an essential management component for Children With Special Health Care Needs (CSHCN) in the school setting. The Kansas Department of Education (KDOE) and KDHE revised the **Guidelines for Serving Students With Special Health Care Needs Part I** in July of 2001. This volume contains a discussion of the Individuals With Disabilities Education Act (IDEA) and Section 504 of the Americans With Disabilities Act and their implications for the practice of school nursing, and delineates laws, regulations, and school personnel responsibilities related to the Individualized Health Care Plan. The Guidelines are available to be viewed, downloaded, and/or printed at the School Health web page www.kdhe.state.ks.us/bcyf/c-f/school.html.

Part II of the Guidelines—Specialized Nursing Procedures—was designed as a companion document to Part I and outlines the specific nursing procedures for maintenance of the student with special health care needs in the school setting. It is written to assist school systems in establishing a safe environment for students with significant health problems. Part II is also available at the School Health web page www.kdhe.state.ks.us/bcyf/c-f/school.html.

Reimbursement for medically necessary services for students who have both and IEP and Medicaid eligibility is accomplished through a bundled rate mechanism. Each school district has a Medicaid provider number. These funds cannot be used to supplant other funding sources and are audited to ensure the provision of special education services, including health services.

Schools also provide administrative services that are necessary for the administration of the Medicaid State Plan. A consultant has been hired through the Greenbush Educational Service Center to document these services and file claims for reimbursement of the federal share of these costs to the schools. Unlike direct services to Medicaid consumers, these claims can be documented through time studies and do not require a separate claim to be filed for each service. SRS will reimburse the federal match, less SRS' administrative costs with non-federal match being certified by the school. Additional information regarding LEA reimbursement through Medicaid can be accessed at www.ksbe.state.ks.us under the School Finance tab on the left.

Nurses working in and with schools are encouraged to negotiate with managed care organizations around the provision of case management services and direct nursing services for these students while in school. Arrangements don't currently exist, but then no one has yet seriously proposed a mechanism for reimbursement to private health care MCOs or direct providers. Think BIG!

KAN Be Healthy/EPSDT

Early and Periodic Screening, Diagnosis and treatment (EPSDT) is a federally mandated program under Title XIX-Medicaid, designated KAN Be Healthy (KBH) in Kansas. It is a preventive health program for Medicaid recipients under age 21. The objectives of the program are to foster good health through the early detection and treatment of conditions, which if left untreated, could become chronic and disabling. Additional information regarding EPSDT can be found at www.cms.gov/medicaid/epsdt/default.asp.

KDHE and The Kansas Department of Social and Rehabilitation Services (SRS)—the state Medicaid agency—have an interagency agreement to provide trained nurses to work in health departments, physician offices and schools to provide KBH/EPSDT screens for infants, children and adolescents in Kansas. The current reimbursement rate for KBH/EPSDT is $60/assessment and must include hearing and vision screening. Nurses trained to provide KBH/EPSDT screens may also provide and seek reimbursement or compensation for child health assessments in other child health programs including WIC, Head Start, and CHASE.

Because of federal regulations, RNs in Kansas cannot bill Medicaid directly for EPSDT screens. In order to bill Medicaid and update the KBH, RNs must have a collaborative agreement with health departments or Primary Care Providers who have a Medicaid provider number in order to bill and update the KBH. *While all school districts in Kansas have their own Medicaid provider number, at this time it is essential that nurses working in and with schools collaborate with community providers outside the school setting for billing and referral purposes, as well as to ensure continuity and quality of care and a medical home for every child and adolescent.*

Any number of arrangements is possible to enable nurses working with and in schools to be reimbursed for EPSDT screens, including

- Schools or school districts contracting directly with health departments or local providers to enable school nurses to provide all or part of the KBH screens at school
- Health departments contracting with schools or school districts to provide KBH screens at schools utilizing health department personnel
- Schools contracting with providers or health departments to monitor KBH status and arrange for students to be transported to and from provider offices using district transportation
- Schools providing the “Early Periodic Screening” component on contract with health departments or other providers who then provide the “Diagnosis and Treatment” component

The opportunities for collaborative arrangements and agreements that benefit schools and provide a health care funding stream for both direct and indirect services at the same time they improve the health status of this most vulnerable population are truly limited only by the imagination of nurses working in and with schools and their ability to think outside the box and communicate their vision to school administration and local providers.

Washburn University currently has a contract with SRS to provide the KBH training, which consists of four (4) clock hours. This training is designed for registered professional nurses (RNs) only, and draws heavily upon educational preparation and experience that is expected to be a part of all nursing curricula.

Information about KBH training can be found at http://www.washburn.edu/ce/health_care/index.html

Registered professional nurses who feel that they need additional coursework or in-service training in addition to that offered as the KBH Training Workshops are encouraged to pursue CNEs and/or college credit that will enhance their skills and confidence level. Educational opportunities specific to child and adolescent health assessment and health supervision utilizing Bright Futures will be posted and updated frequently on

www.kdhe.state.ks.us/bcyf/c-f/zips/index.html

School Site Immunization Programs and Immunization Clinics

Nurses working in and with schools are encouraged to partner with local health departments to develop similar immunization efforts at the school site. Immunization administration is well within the scope of practice of professional nurses, and has potential for the generation of revenue as well as the potential for meeting state mandates and public health recommendations. *Someone*, somewhere is going to get paid for administering most of those vaccines—that money can go to school districts in support of school health services just as easily as it go to local health departments and providers!

A little out of the box thinking will go a long way toward creating a system that keeps students in school instead of excluding them for noncompliance, provides an important public health service, and generates income for school health services at the same time. Nurses working in and with schools are encouraged to consider memoranda of understanding (MOUs), memoranda of agreement (MOAs), and contractual arrangements to allow school nurses and school health programs to reap some of the potential financial benefits of immunization administration as a health service, document valuable immunization information in the health department immunization registry, and review health department immunization records to determine immunization status for students.

Information about school based immunization programs is available through The American School Health Association's "Roll Up Both Sleeves!" publication, www.immunize.org/genr.d/issue25.htm#n2 and http://www.immunize.org/genr.d/issue59.htm

Vaccines for Children

In 2000, Healthy People 2010, with the Centers for Disease Control and Prevention (CDC), set immunization goals for the year 2000 that call for at least 90% of children to have completed the primary series of childhood immunizations. The Vaccines for Children Program works to reduce vaccine cost as a barrier to the immunization of children. School districts collaborating with local health departments can enroll as VFC providers. Vaccine itself must be provided free of charge since it is free to you, but an administration fee of up to $10/immunization may be charged in Kansas as long as no one is refused vaccine due to inability to pay the administration fee.

Children eligible for free vaccine through the VFC Program are persons age birth through age 18 years who fall in one or more of the following categories:

- Without health insurance
- Enrolled in Medicaid
- American Indian or Alaskan Native (as identified by the parent or guardian)
- Underinsured–Meaning the child has some type of health insurance but it does not include vaccines as a covered benefit.

These children are eligible for VFC vaccines only at Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) that are officially registered. (Schools can develop collaborative efforts with FQHC and RHC as well as local health departments).

The Vaccines for Children Program guarantees a supply of all vaccines necessary to immunize VFC eligible children, based on the Advisory Committee for Immunization Practices (ACIP)

recommendations. If you are a health care provider enrolled in the VFC Program, you will order and receive vaccine at no cost.

On the Annual VFC Provider Enrollment/Profile Forms, you identify your type of practice (e.g., private practice, hospital, rural health clinic, school) and estimate the number of children to be immunized in your practice, as well as the number of those children who will be VFC eligible. Your State Immunization Program will keep this record on file and will refer to it each time you place an order for vaccine. Vaccine is provided using multiple funding sources. The document will be used to assist in apportioning your order by funding source. You will need to update and submit this information annually, and may revise it as often as necessary.

The vaccines and combination vaccines offered with the VFC program are those providing protection against twelve diseases: diphtheria, haemophilus influenzae type B, hepatitis B, measles, mumps, rubella, pertussis, poliomyelitis, tetanus, varicella, pneumococcal, and influenza. As new vaccines and combinations are approved by the FDA and recommended by the ACIP, they will be added.

Information regarding the Kansas Immunization Program, including the State Immunization Manual, forms, and Vaccines for Children (VFC) information is available from the web page at www.kdhe.state.ks.us/immunize/index.html

TeleKidcare

Launched in the spring of 1998, TeleKidcare (http://www2.kumc.edu/telemedicine/programs/telekidcare.htm) linked four school nurses from the Kansas City, Kansas School District (USD 500) with physicians from the University of Kansas Medical Center (KUMC) for clinical consultations via telemedicine technology. Using a computer, a camera, and special software, the nurses and students could see, hear, and interact with the physician in real time for diagnosis and treatment of acute conditions as well as certain chronic conditions. Physicians were also able to communicate directly with family and other school personnel as appropriate.

TeleKidcare® was conceived by school nurses recognizing the need to partner with primary care providers to break through the economic and physical barriers to health care. Telemedicine technology allows underserved children to access physicians through their school nurse's office and helps kids get healthy faster, so they can be in school doing what they should be doing...LEARNING! School based telemedicine provides a safe, non-threatening environment to facilitate the movement of many families into an established health care delivery system.

Those original four sites have spread across the state, spurred on by the Governor's annual allocation of $250,000 in state funding to expand the project into more rural areas. Currently 35 Kansas schools have access to KUMC and local primary care providers through telemedicine technology.

Keep in mind even with telemedicine, there must be a registered nurse in the health room during the assessment, as "nursing actions that involve judgment may never be delegated" (Kansas Nurse Practice Act, 2000). For more information about the delegation laws in Kansas go to http://www.ksbn.org.

Reimbursement for TeleKidcare® consults is currently under negotiation with Medicaid, and it is hoped private insurance coverage will follow. For more information concerning TeleKidcare® and the request for proposals (RFP) for TeleKidcare®, visit the KUMC website at http://www2.kumc.edu/telemedicine/programs/telekidcare.htm

SB 10

During the 2004 Legislative Session, legislation was passed as part of SB 340 that authorized the self-administration of asthma and anaphylaxis medication by students in grades 6 through 12 and permitted the authorization for students in kindergarten and grades 1 through 5. The legislation relating to self-administration of medication included a one-year sunset provision. As part of its Committee Report to the 2005 Legislature, the Legislative Educational Planning Committee recommended changes to the current Kansas law to incorporate provisions in recently enacted federal law. The federal law would give states, that have self-medication policies that extend to elementary children, preference with regard to federal grants that are asthma related.

As amended, SB 10 modified current law concerning the administration of medication by elementary and secondary students. Specifically SB 10:
Required that each school district adopt a policy authorizing self-administration of medication for students in kindergarten and grades 1 through 5 in addition to the currently authorized grades 6 through 12. Also the sunset provision was removed that SB 10 passed into law. For more information and to view SB 10 visit the Kansas Legislature Website at:
http://www.kslegislature.org/bills/2006/10.pdf

Comprehensive School Health Centers

Comprehensive School Health Centers (CSHC)

The purpose of the KDHE-BCYF initiative is to increase the accessibility and availability of quality primary and preventive physical, mental and dental health care services to preschool, elementary, middle and secondary school students in high-risk areas of Kansas.

This program was established in recognition of the need to improve primary and preventive health care of children in low-income, high-risk communities. Since 1981, state, federal and private foundation funds have been used to develop and implement projects to provide these expanded school health services for pre-school and school age children through health teams composed of school nurse, advanced registered nurse practitioners, physician assistants, community health aides, collaborating physicians, social workers, psychologists, collaborating psychiatrists, health educators, nutritionists, dentists and dental hygienists.

The objective of the CSHC is:

- To promote good physical, mental, and dental health;
- To prevent illness leading to disability and hospitalization;
- To improve the delivery of primary and preventive healthcare services by ensuring that they are accessible, coordinated, comprehensive, collaborative and skilled for all children and youth, including those with special health care needs;
- To facilitate learning and improved school attendance; and
- To promote healthy living by providing comprehensive school primary and preventive health care to medically underserved youth through community partnerships that include community health care providers and school districts.

Program activities include:

- Provide comprehensive school health services;
- Provide on-site management of chronic or disabling conditions;
- Assure continuity of care by making staff and services available at the school and in coordination with the student's medical home;
- Educate parents and guardians to the need for preventive health care;
- Use positive youth development assets approach in developing programs intended to reduce risk behaviors;

- Provide on-site services at no cost to the individual student but access appropriate Medicaid and other third party reimbursement and develop and utilize medical home partnerships to enable cost-effective health care delivery to the school aged population; and
- Refer and link children with special health needs to appropriate community resources.

CSHCs offer comprehensive age-appropriate primary health, mental and dental services including:

- comprehensive physical health, mental, and dental health assessments;
- diagnosis and treatment of acute illnesses and chronic conditions (e.g. asthma);
- screenings and referral (e.g., vision, hearing, dental, nutrition, TB);
- routine management of chronic diseases (e.g. asthma and diabetes);
- health education;
- mental health counseling and referral;
- immunizations;
- required school entry and sports physicals;
- referral and follow up; and
- population-based primary prevention services.

Services are provided on site by a multi-disciplinary team consisting of the school nurse, a mid-level practitioner, a mental health counselor, and a medical assistant in consultation with a physician. The community health center, or public health department that sponsors the comprehensive school health center ensures access to care and assures continuity of care when school is closed.

All children and youth in schools with a comprehensive school health center who have a signed parental consent form are eligible to receive services.
For more information contact: Jane Stueve, Adolescent and School Health Consultant
at 785-296-1308 or email her at: jsteuve@kdhe.state.ks.us.
Visit the Comprehensive School Health Services Center webpage at:
http://www.kdhe.state.ks.us/c-f/comp_school_health.html

FERPA and HIPAA

FERPA is the federal Family Educational Right to Privacy Act, also known as the Buckley Amendment. http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html and http://www.epic.org/privacy/education/ferpa.html. It is designed to protect the privacy of student education records and to ensure that parents have access to those records. Each record must have an access log which includes the reason for access, which in turn must be for a "legitimate educational interest."

HIPAA is the Health Insurance Portability and Accountability Act of 1996 aspe.os.dhhs.gov/admnsimp/pl104191.htm. It literally creates a new standard for privacy and security in identifiable health information—regardless of the setting. In the final regulations, schools are for the most part exempted from HIPAA precisely because FERPA is supposed to be protecting their health information if it is a part of the school record. However, if schools submit electronically for Medicaid reimbursement (as Kansas schools do), it is still unclear if they are subject to FERPA or HIPAA. Information clarifying this issue will be disseminated as it becomes available.

The Kansas Department of Education maintains the position that any record generated at or received by the school is part of the educational record and is regulated by FERPA. Nurses and physicians providing health care services in the non health care environment of the schools often find themselves in the very awkward position of trying to juggle the confidentiality expectations of their employer (the schools) and their profession (health care). Nurses working in and with schools often find themselves tangled in the "who needs to know" web of health care information dissemination. As ***THE*** person in the schools who is accountable for identifiable health information, nurses in schools must be aware of their responsibilities under FERPA and HIPAA and be able to train those who are privy to identifiable health information. This affects everything they do: talking to parents, maintaining in a paper or electronic student health record, sharing information with teachers and administrators, choosing an information system, faxing, email— everything.

Where health records are concerned, nurses need to ensure that district policy defines "legitimate educational interest" both in terms of those who need to know to benefit the student, ***and*** *those who have the expertise to understand and interpret the health information and its' relationship to educational needs.* As a general rule, the school health professional (nurse, nurse administrator, physician) should maintain and interpret student health records. "Need to know" information should be incorporated into individualized health care plans and anticipated health crisis plans and shared only with appropriate school administrators, teachers and student assistance teams serving the specific student in question.

The resources listed below are excellent resources for additional information regarding health records in schools: Nadine Schwab and Mary Gelfman's book in particular is *indispensable* for effective nurse practice in the school setting.

Bergren, M.D. (2004). HIPAA-FERPA revisited. Journal of School Nursing, 20(2), accepted for publication.

Schwab, N. (2003). School nurses role in education privacy standards for student health records. National Association of School Nurses. http://www.nasn.org

Levin, M. & Lally, P. (2003, January). What to do if the HIPAA Beast is at your door, 1-4. Inquiry and Analysis. http://www.nsba.org/site/index.asp

Bergren, M.D. (2003). National Conference on HIPAA Privacy Rule, NASN Newsletter, 18 (4), 20-22. www.nasn.org

InFocus (2003, January 13). The other health privacy law: What FERPA requires for schools. http://www.healthinschools.org/focus/2003/no1.htm

Schwab, N & M. Gelfman (Eds.) (2001). Legal issues in school health services: A resource for school nurses, administrators and attorneys. North Branch, MN: Sunrise River Press. 1-800-895-4585 www.schoolnursebooks.com

Bergren, M.D. (2001). HIPAA hoopla? Journal of School Nursing, 17, 336-340.

National Task Force on Confidential Student Health Information. (2000). Guidelines for protecting confidential student health information. Kent OH: American School Health Association available through NASN web page www.nasn.org

Schwab, N., Panettieri, M. J., Bergren, M. D. (1998). Guidelines for school nursing documentation: Standards, issues, and models. Scarborough, ME: National Association of School Nurses. Available through NASN web page www.nasn.org
The Administrative Simplification (AS) Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). aspe.os.dhhs.gov/admnsimp/pl104191.htm Do a search using FIND for FERPA

Bergren, M. D. (1999). Criteria for software evaluation: Legal issues. Journal of School Nursing, 15(2), 32-33. Members can now access the entire *Journal* on the web. All you need is your Member ID #, which you will find on the mailing labels used to send you the Journal and NASN Newsletter. nasn.allenpress.com.

Bergren, M. D. (1999). Legal issues: Office management practices. Journal of School Nursing, 15(3), 40-41. nasn.allenpress.com.

Family Educational Right to Privacy Act. www.cpsr.org/cpsr/privacy/ssn/ferpa.buckley.html National Association of State School Nurse Consultants, 2000 Confidentiality of Health Information in Schools, lserver.aea14.k12.ia.us/swp/tadkins/nassnc/nassnc.html

National Task Force on Confidential Student Health Information. (2000). Guidelines for protecting confidential student health information. Kent OH: American School Health Association Available to order through www.nasn.org

Schwab, N., Panettieri, M. J., Bergren, M. D. (1998). Guidelines for school nursing documentation: Standards, issues, and models. Scarborough, ME: National Association of School Nurses. Available to order through www.nasn.org

Delegation of Nursing Tasks and Procedures in the School Setting

The reality of nursing practice in the school setting has resulted in an acknowledgement of the need for delegation to unlicensed assistive personnel (UAPs) for specific nursing tasks and medication administration. Those nurses who are responsible for multiple buildings, who work less than full time, or who may have caseloads too large for a single practitioner may find themselves needing to delegate to UAPs to meet the needs of their students.

The Kansas Board of Nursing has been established to protect the public health, safety and welfare of the citizens of Kansas through the licensure and regulation of nursing practice. The **Kansas Nurse Practice Act** is the legal document regulating the practice of every registered professional nurse (RN) and licensed practical nurse (LPN) in the state of Kansas. It dictates the scope of practice for all professions regulated by the Kansas Board of Nursing, regardless of practice setting.

The Kansas Board of Nursing has the ultimate legal authority to interpret these laws relating to the practice of nursing, wherever the nurse may practice in the state. **This is the authority that governs the practice of every school nurse in Kansas, regardless of who employs them or the setting in which they practice.** The Kansas Nurse Practice Act can be viewed, downloaded and printed at www.ksbn.org/npa/npa.htm

The following bullets are a summary of the section of the Kansas Nurse Practice Act entitled **Performance of Selected Nursing Procedures in the School Setting**, which directly relates to the practice of school nursing. Nurses practicing in schools are subject to all of the provisions of the Nurse Practice Act, however this section is most specific to the nurse in the school setting. **K.A.R. 60-15-101 through 60-15-104 of the Kansas Nurse Practice Act specific to Performance of Selected Nursing Procedures in the School Setting carries the force of law**, and must be considered when creating policies for local school districts. These provisions can be accessed through the links below, or through the links at www.kdhe.state.ks.us/bcyf/c-f/school.html

- Only a registered professional nurse (or a physician provider) has the authority to delegate the administration of medication or other nursing procedures in schools, and then only with appropriate and adequate training, supervision and performance evaluation of the delegate as referenced in **K.A.R. 60-15-101. This regulation in the most current form can be viewed, downloaded and printed at** www.ksbn.org/npa/pages/60-15-101.doc

- Nursing procedures in the schools can only be delegated in accordance with **K.A.R. 60-15-102**. This includes a nursing assessment of the student, the formulation of a student plan of care and the formulation of a delegation plan of care. **This regulation in the most current form can be viewed, downloaded and printed at** www.ksbn.org/npa/pages/60-15-102.doc

- The supervision of delegated nursing procedures in the schools must be done in accordance with **K.A.R. 60-15-103**. This includes the registered nurses' responsibility for assessment of the degree of supervision required after taking into account the health status and stability of the student receiving nursing care, the complexity of the task or procedure to be delegated, the competency and training of the person to whom the task is delegated, and the proximity of the supervising RN to the student and delegate. **This regulation in the most current form can be viewed, downloaded and printed at** www.ksbn.org/npa/pages/60-15-103.doc.

****Because new medications and procedures with implications for school nurse practice are constantly being approved and introduced, school nurses and administrators are encouraged to seek interpretation from the Kansas Board of Nursing if questions arise. Specific practice questions regarding performance and delegation of nursing procedures, including medication administration in the school setting should be directed to Diane Glynn, the Practice Specialist at the Kansas State Board of Nursing diane.glynn@ksbn.state.ks.us. The Kansas Board of Nursing website can be accessed at www.ksbn.org/****

A set of **Guidelines/Best Practices for Medication Administration in Kansas Schools**
http://www.kdhe.state.ks.us/c-f/downloads/guidelines_for_medication.pdf
has been developed and endorsed by the Kansas Department of Health and Environment, the Kansas School Nurse Organization, the Kansas School Health Committee of the American Academy of Pediatrics, and the Kansas Pharmacist's Association. Representatives from the Kansas State Board of Nursing, the Kansas Nurses' Association, the United School Administrators, the Kansas Association of School Boards, and the Kansas State Department of Education have reviewed and provided input for these revisions. **K.A.R. 60-15-101 through 60-15-104 of the Kansas Nurse Practice Act specific to Performance of Selected Nursing Procedures in the School Setting carries the force of law** and will be referenced in the guidelines as a Kansas Administrative Regulation (K.A.R). *The guidelines themselves have not been adopted as administrative rules or regulations and therefore, are not binding upon local boards of education* ***except*** *for the inclusion of the above referenced regulations.*

The guidelines are available through the School Health website at:
www.kdhe.state.ks.us/bcyf/c-f/school.html.

Additional information on delegation supervision of delegated tasks and procedures in schools is available through the Guidelines For Children With Special Health Care Needs available at www.kdhe.state.ks.us/bcyf/c-f/school.html, the NASN position statement on Delegation at http://www.nasn.org/positions/2002psdelegation.htm
and the NASN issue brief on Delegation of Care at
http://www.nasn.org/briefs/2004briefdelegation.htm

OSHA and Blood Borne Pathogens

OSHA's mission is to ensure safe and healthful workplaces in America. Since the agency was created in 1971, workplace fatalities have been cut in half and occupational injury and illness rates have declined 40 percent. At the same time, U.S. employment has doubled from 56 million workers at 3.5 million worksites to 111 million workers at 7 million sites. More information is available at the OSHA web site at www.osha.gov.

Over the past few years, significant medical advances have occurred to help control bloodborne pathogens. OSHA has clarified the standard through written interpretation in a revised compliance directive. Although public schools are not legally required to follow OSHA guidelines, KDHE-BCYF Children and Families supports and encourages all schools to adhere to these regulations. As part of a school district's Exposure Control Plan, the chief administrative officer, with the advice of the school nurse, Centers for Disease Control guidelines, KDHE, local health departments, and individual district policies should adhere to the following key revisions, promulgated by NASN and found in the http://www.nasn.org/positions/2003psbloodborne.htm

- Develop and annually review a written Exposure Control Plan designed to protect employees from possible infection caused by contact with bloodborne pathogens as a result of performing job duties. The plan should reflect consideration and use of commercially available safer medical devices (needleless systems, shielded devices, or safety features designed to reduce the likelihood of injury), safe work practices, administrative controls and personal protective equipment.
- Determine which employees could reasonably be expected to have exposure to bloodborne pathogens or other materials potentially contaminated with blood as a result of performing job duties.
- Provide effective training and education for all employees, emphasizing interactive learning that allows opportunity for discussion with a qualified trainer and also additional training for occupationally exposed employees whenever safer devices are implemented. The emphasis in training should rely on relevant evidence. FDA approval will help ensure the effectiveness of devices designed to prevent exposure to bloodborne pathogens.
- Provide Hepatitis B vaccine for occupationally exposed employees and incorporate Centers for Disease Control guidelines on post-exposure evaluation and follow-up for HIV and the Hepatitis C virus.
- Communicate the reporting procedure for exposure incidents to all employees.
- Provide immediate post-exposure medical evaluation and follow-up.
- Facilitate record keeping in compliance with applicable laws and guidelines about confidentiality of health records.
- Recognize the threat to employees responsible for direct student care (often nurses working in and with schools) who are potentially exposed to injuries from contaminated sharps. Needlesticks and other percutaneous injuries continue to be of concern due to the frequency of their occurrence and the severity of health effects associated with them.

The OSHA Blood Borne Pathogens Regulations (Standards) include definitions and the details of an exposure control plan. The Exposure Control Plan may be developed locally, or based on a template from a local health department, clinic or hospital, or a neighboring school district.

Managing Emergencies

The events of 9/11 put a new spin on the issue of school and community emergencies. School shootings, suicide pacts, tornadoes and bomb threats never motivated communities in general or schools in particular to prepare for disaster the way that 9/11 has. In the past, managing school emergencies generally referred to medical management of injured students/staff and possibly planning for the possibility of an intruder in the building. A new realization of our vulnerability and the responsibility of the schools to the community have gripped us and is the driving force behind a concerted effort to ensure that there is a plan for managing school and community emergencies in an effective and efficient manner.

An emergency is any sudden event, which endangers or threatens to endanger the safety or health of any person or which destroys or threatens to destroy or damage property or endangers or threatens to endanger the environment or an element of the environment. An emergency includes any incident, which occurs during school hours, or after school hours, during camps, excursions or outdoor adventure activities, during travel to or from school and incidents which involve issues of negligence or legal liability. Emergencies which should be planned for include but are not limited to:

- fatality/suicide
- serious injury/serious assault/sexual assault
- siege/hostage/firearms
- disappearance or removal of students from school or home
- bomb threats
- collapse/major damage to buildings or equipment
- motor vehicle collisions
- fire in school buildings/bushfires
- impact by equipment/machinery/aircraft
- fumes/spill/leak/contamination by hazardous material
- outbreak of disease
- flood/tornado or other natural event
- witnessing or learning about traumatic events.

School administrators are responsible for developing an emergency response plan. In an emergency situation, school officials, media, community members, fire, police, health officials, volunteer agencies, and government representatives will have to function together to meet the needs of the community. In order to minimize the impact of an emergency, it is essential to know the risks, assess the resources and training needs, and develop plans ahead of time for immediate response as well as the recovery stage.

Nurses working in and with schools have a vital role in each phase of emergency planning and management. They are in a unique position to assess potential emergency risks and assess the effectiveness of emergency trainings and practice activities. They are on the front line where kids and families are when an emergency occurs. They respond to all serious adverse events that threaten the health, safety, or well being of a school. In particular, school nurses have unique knowledge of children with special health care needs and are of utmost importance in the planning and responding phases of emergency management. The role of these nurses places them in a strategic position to assist in the short-term and long-term recovery phase after an emergency has occurred. They are also essential players on teams that review and evaluate a school's response to an emergency. Continuous integration, coordination, and training of all school and community health providers are the keys to the reduction of injury and death in any school/community disaster.

Children, Bioterrorism, and Disasters

The AAP has compiled resources and materials on disasters and bioterrorism, including information concerning anthrax and smallpox and psychological support of children. These can be accessed at www.aap.org/advocacy/releases/cad.htm

Information specific to bioterrorism response can be found at the CDC website at www.bt.cdc.gov/. Information specific to Kansas concerning bioterrorism response and preparedness is available at www.kdhe.state.ks.us/han/bioterror.html, the Kansas Bioterrorism Response, Preparedness, and FAQ sheet site.

The US Department of Health and Human Services Office of Emergency Preparedness website can be accessed at ndms.dhhs.gov/.

The American Red Cross information for Disaster Services Preparation can be found at www.redcross.org/services/disaster/beprepared/.

The Federal Emergency Management Agency (FEMA) website can be accessed at http://www.fema.gov/

Emergency Guidelines for Schools

KDHE, Children and Families Section, has adopted the emergency guidelines produced by the Illinois Emergency Medical Services for Children (EMSC) program, Loyola University Health and the Illinois Department of Health.

The emergency guidelines are meant to serve as basic "what to do in an emergency" information for school staff without medical/nursing training when the school nurse is not available. **It is strongly recommended that staff who are in a position to provide first aid to students complete an approved first-aid and CPR course. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor.**

The guidelines were created as a **recommended** procedure. It is not the intent of these guidelines to supersede or make invalid any laws or rules established by a school system, a school board, or the State of Kansas.

To view and download these guidelines visit:
http://www.luhs.org/depts/emsc/Schl_Man.pdf

Do Not Resuscitate (DNR) Orders

Advances in medicine and technology have led to the survival of many children who previously would have died of life-threatening conditions. As these children with problems reach school age with these conditions, families, health care providers, and educators have to deal with the challenges involved in their care. Some children may be at high risk of dying while in school. When families have chosen to limit resuscitative efforts, school officials must understand the medical, emotional, and legal issues involved.

A request for do not resuscitate (DNR) orders from a parent to school personnel may very well represent the parent's and in some cases the child's wish for the school to recognize the stage of the child's illness. A DNR order does not mean abandonment of all medical treatment and does not, of

itself, rescind the obligations of the health care team to provide quality care, such as suction, oxygen, and/or pain medications. It is a dynamic part of the management plan to be reviewed with the family and significant adults in the child's life, including those at school.

Decisions to limit potentially lifesaving therapies for a child always involve considerable emotional turmoil and careful deliberation about the actual goals of treatment. The parents, primary care providers, and specialist, the faith community, and the child try to decide what actions would further the best interests of the child. When a DNR order is issued, the decision-makers have already carefully weighed the potential harm of intervention against the potential benefit.

On the other hand, if schools do not employ professional registered nurses, they may have legitimate concerns that a DNR order could be misinterpreted by medically untrained staff, resulting in harm, or they may worry that personnel would not respond to an easily reversible condition, such as a mucous plug in a child with a tracheostomy. The Kansas Association of School Boards (KASB) has expressed concerns about school personnel responding to circumstances not anticipated by a DNR order (choking on food, injury, etc.). School officials are understandably concerned that they and/or the school or school district could be held liable if employees failed to act in a way that might have prevented a death, rather than responding by not resuscitating a child in true cardiac or respiratory arrest.

While registered professional nurses generally understand and embrace the concept of death with dignity, it is a construct not readily accepted by non-health care personnel. School officials and parents of healthy children may have very real concerns about the trauma of exposing children to death, since the very nature of sudden cardiac or respiratory death is its unpredictability—it represents a loss of control of the environment for administrators and parents of healthy children.

Information concerning DNR orders can be found in the Guidelines for Serving Children With Special Health Care Needs available on the school health web page at: www.kdhe.state.ks.us/bcyf/c-f/school.html.

The AAP policy statement on DNR orders at school can be accessed at: www.aap.org/policy/re9842.html .

The NASN position statement on Do Not Resuscitate Orders can be accessed at: http://www.nasn.org/positions/2004psresuscitate.htm

A meeting was held in the fall of 2001 with legal representatives from KDHE, the Kansas Board of Healing Arts (KBHA), the Kansas Department of Education (KDOE), the Kansas Board of Nursing (KSBN), the Child and School Health Consultant, and the Director of KDHE Children and Families to try to reach a consensus on the critical issue of the legal status of DNR orders in the school setting in Kansas.

The Department of Education, while maintaining that this is a medical issue, not an educational issue, did make it clear that if a school district follows the policy recommendation of the Kansas Association of School Boards (KASB) that districts NOT honor DNR orders, the school nurse as the health care advocate for a child or adolescent may/should encourage the parents to pursue Due Process to have the order enforced.

Due Process is a function of IDEA and is designed to provide families with a venue for the impartial resolution of complaints concerning provision of services to children and adolescents with special needs. A copy of the form to submit a request for Due Process Hearing can be found at the Department of Education website www.ksde.org/ . Click on Student Support Services under KSDE Divisions and Teams. Then click on Legal Requirements, **OR** click on Due Process Procedures and Forms under Legal Requirements.

Communicable Disease Control

State Regulations Administered by Epidemiologic Services
Note: Some of the files linked below require the Adobe Acrobat Reader® plug-in. For assistance with download, installation, or use of the plug-in, please contact Adobe Systems, Inc.®

The following regulations represent an electronic facsimile of Kansas Administrative Regulations, promulgated by the Kansas Department of Health and Environment and published by the Kansas Secretary of State as of February 18, 2000, which may relate to infants, children, adolescents, or schools in general. These rules are taken from electronic copies of the printed state regulations, which serve as the agency's official rules and regulations. The printed regulations represent the final word in matters of interpretation.

The KDHE Office of Public Information has appended copies of the *Kansas State Register* publication of new or amended, permanent KDHE regulations to the appropriate chapter. Those amendments are noted on the cover sheet for each chapter. In the interest of saving space, some chapters have been grouped together.

28-1-2. Designation of infectious or contagious diseases. *NOTE THAT PEDICULOSIS IS **NOT** AN INFECTIOUS OR CONTAGIOUS DISEASE, DESPITE THE HYSTERIA IT GENERATES IN SCHOOLS!* The Kansas Classroom Handbook on Communicable Diseases (see below) does mention pediculosis, however, a more appropriate resource for nurses working with and in schools would be the Fact Sheet also produced by the Bureau of Epidemiology:

- Dealing with Head Lice: A Practical Approach for Schools, Parents, and Communities
- 28-13. Rabies Control
- 28-14. Rabies Control - Wildlife Animals
- Animals in Kansas Schools: Guidelines for Visiting and Resident Pets (AB1007) (.pdf)

The purpose of these guidelines is to provide information to promote safety for instructors and students when animals are brought into the classroom.

- Hair Braiding Outside of Cosmetology Establishments: Infection Control Guidelines for Providers (.pdf)

These recommendations are provided as guidance to individuals who practice hair braiding outside of regulated cosmetology establishments (as defined by K.A.R. 28-24-1) for the purpose of reducing the risk of transmission of infectious diseases or infestations in such settings.

- Health Education Fact Sheets

These fact sheets and brochures address public health issues under the agency's jurisdiction. Public health issues are those that can be impacted by the implementation of community based intervention strategies, like hand-washing to control an outbreak of Shigellosis or recycling to reduce the burden

on our solid waste landfills. There are some health problems you won't see mentioned here, not because they're unimportant, but because KDHE focuses on *public* health concerns. There are a number of Web sites around the world that can be searched to find information on those other health issues. As with any advice, it is general in nature. If after reviewing KDHE information you have questions about personal health, contact the family or family physician. Bookmark this page as KDHE will update it with new informational materials. The list is organized alphabetically.

The Kansas Classroom Handbook on Communicable Diseases document can be downloaded by visiting:
http://www.kdhe.state.ks.us/bedp/download/infectious_reportable_diseases_regs.pdf

The classroom handbook for school nurses is intended as a brief overview of infectious diseases that are of public health importance. These diverse diseases include childhood vaccine preventable diseases such as measles to gastrointestinal diseases that can be transmitted by contaminated food or from person-to-person.

There are two main sections in this handbook. The first section includes statutes and regulations related to communicable diseases that school nurses may need to refer to. The second section is disease-specific, with diseases listed alphabetically and containing key information on symptoms, modes of transmission, and measures of control. This handbook is authored and provided by the Epidemiologic Services section, Bureau of Epidemiology and Disease Prevention, Kansas Department of Health and Environment (KDHE).

For further information on communicable diseases and their control, school nurses can call their county health department or KDHE (785/296-2951).

The infection control guideline on MRSA and VRE is intended as a quick reference for patient care providers in various settings, including long term care, home care and schools. Some recommendations may not apply to all settings. This guidelines supplements CDC and Hospital Infection Control Practices Advisory Committee (HICPAC) for managing VRE colonized or infected patients.

For more information visit: http://www.kdhe.state.ks.us/epi/download/vre.pdf

Nurses working in and with schools may also find the following links useful:

- CDC Home Page
- CDC Traveler's Health Page
- Disease Reporting for Kansas Health Professionals
- Health Alert Network - KDHE's Bioterrorism Response Program
- KSU - Rabies in Kansas
- KSU - West Nile Virus

Refugee, Immigrant and Migrant Health

Immigrant children and their families have numerous risks to physical health and functioning and are frequently unfamiliar with the provision of health care services in the United States. The term “immigrant children" includes those who are legal and illegal (undocumented) immigrants, refugees, and international adoptees. These children face many barriers to care, and their special risks and needs may not be readily apparent. Recently enacted federal welfare and immigration reform measures may well increase the vulnerability of this population by limiting its access to health and social services. For multiple ethical and medical reasons, KDHE Children and Families section, has historically opposed and continues to oppose, denying needed health care services—including preventive health care—to any child residing in Kansas.

A number of factors may increase the health risks of immigrant infants, children and adolescents:

- Families may be unemployed and unfamiliar with English. Children may have undiagnosed health problems such as tuberculosis, parasites, HIV infection, or lack of immunizations. Families generally have very limited knowledge of care-seeking behaviors and the US health care system.

- International adoptees may arrive without records documenting their medical and social history. They often join families with whom they have no common language or physical similarities and might be adopted by parents who have no experience with child-rearing.

- Many immigrant children have significant problems accessing health care services. Immigrant families tend to seek medical services on an episodic basis and through emergency rooms rather than through a medical home, limiting the provision of coordinated, longitudinal care. Day to day issues of survival including uncertainty about food, clothing, and shelter may put health concerns (especially preventive health concerns) at the bottom of the list.

- *Legal* immigrants residing in Kansas before passage of the Personal Responsibility and Work Opportunity Act of 1996 are eligible for Medicaid. Legal immigrants entering the country *after* 1996 are eligible for Medicaid only after 5 years in residence. *Illegal immigrants, however, qualify for very little public assistance. Legal **and** illegal immigrants not eligible for Medicaid are covered for emergency services, such as labor and delivery and life threatening trauma care, but not for preventive services, such as prenatal or well-child care.*

- Fear of apprehension by immigration authorities, cost, language and cultural barriers may restrict access of immigrant children to preventive services. Families may delay seeking care for minor conditions until those conditions become more serious or even life threatening. It often happens that various family members have varying immigration status. If one member of the family is in this country illegally, the entire family may limit access to care for fear of triggering investigation.

- Immigrant children may harbor infectious diseases such as malaria, amebiasis, schistosomiasis, and other helminthic infections; congenital syphilis (foreign-born children are not necessarily screened at birth); hepatitis A; hepatitis B, particularly in immigrants from Southeast Asia; and tuberculosis, that the US health care system may be inexperienced in diagnosing and treating in children.

- International adoptions have increased to a current rate of more than 10,000 per year. These children are for the most part from Korea and Central and South America but are also from Romania, the Balkans, China, Eastern Europe, and the Caribbean. It has been estimated that more than 50% of these children have at least one health problem at the time of arrival in the US, often infectious diseases. In addition, many immigrant children have not been immunized adequately or lack appropriate documentation of immunization status.

- Separation from support systems; differences in social, professional, and economic status in the country of origin and the United States; and ongoing depression, grief, or anxiety resulting from relocation to a new community and culture as well as traumatic events that may have occurred in the country of origin frequently pose severe stresses on children and families.

- Immigrant and refugee children may have difficulty adapting to school. Prior education or lack of education, limited English proficiency, and separation from family while at school may affect school performance and result in learning disabilities.

- Extended families and traditional health care practices are prominent in many immigrant cultures. They are an important source of strength, but they also may create conflicts with use of health services and adaptation to American health care customs. Children and families uprooted because of war or persecution have experienced terrible losses and witnessed atrocities and are in need of mental health and social services. Posttraumatic stress disorder (PTSD) and other psychiatric disorders are not uncommon in immigrant children with this background.

- Dental problems are more frequent among immigrant children. Immigrant elementary school children have been found to have twice as many dental caries in primary teeth as their US counterparts, with as many as 75% having dental disease identified on first screening in the United States.

Immigrant children have been found to be at risk for height-for-age and weight-for-age deficiencies. Within 1 year, many have experienced significant catch-up growth. Internationally adopted children, who may have been placed in orphanages or group foster homes before their placement in adoptive homes in the United States also tend to have high rates of delay in meeting anthropometric measures and may be at increased risk for developmental delay.

An excellent resource for addressing the health care needs of refugee, immigrant, and migrant populations can be found in the Provider's Guide To Quality and Culture. This is a joint project of Management Sciences for Health (MSH) and the US Department of Health and Human Services, Health Resources and Services Administration. It contains information on culture and quality of care for a number of specific cultural groups including African, Arab, Asian, Central Asian, Hispanic/Latino, Muslims, Native Americans, Pacific Islanders, and South Asians.

The Ethnomed site at www.ethnomed.org/ has culturally specific health information for a number of cultural groups including Amharic, Cambodian, Chinese, Eritrean, Ethiopian, Mexican, Oromo, Somali, Tigrean and Vietnamese.

The KDHE Office of Local and Rural Health (OLRC) website has information specific to refugee populations in Kansas at www.kdhe.state.ks.us/olrh/resources_researchers.htm and www.kdhe.state.ks.us/olrh/RefugeeOverview.htm.

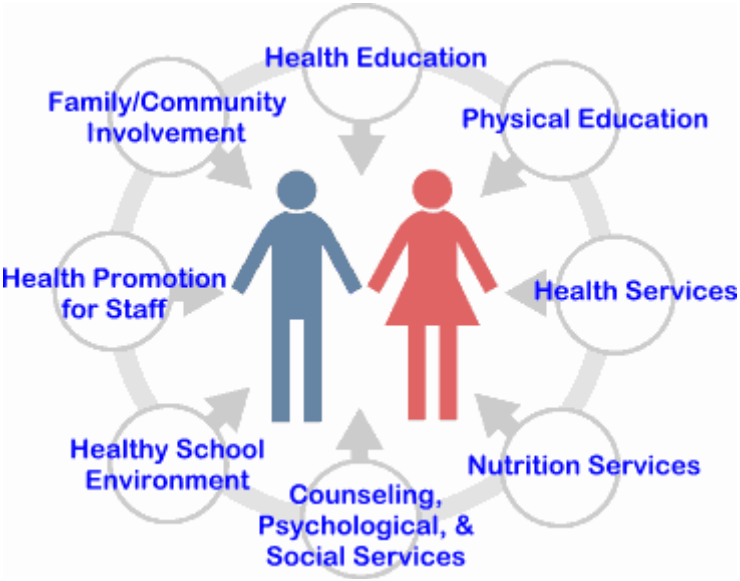
Information concerning Migrant (Farmworker) Health in Kansas can be accessed at www.kdhe.state.ks.us/olrh/FW.html.

The Children's Defense Fund has posted a website to help clarify issues surrounding CHIP/Medicaid and Immigration Law. The website can be accessed at http://www.childrensdefense.org/

Coordinated School Health

Kansas' children and adolescents—nearly half a million of them—spend six hours/day in school, 180 days out every year. That's well over 1,000 hours/year—about the same amount of time they will spend in direct contact with parents and guardians (National Institute of Child Health and Development, 2000). www.nichd.nih.gov

Because of the size and accessibility of this population, school health programs are one of the most efficient means of shaping our state's future health and social well-being. A **Coordinated School Health Program** is a blueprint for a multi-strategy approach to promote the healthy development and well-being of everyone in the school community as an integral part of every school's mission. It is a blueprint based on a vision of every student as a successful, healthy lifelong learner, and has eight basic components as illustrated below.



The Coordinated School Health initiative has emerged in response to the state of children's health and education. It is an organized set of policies, procedures and activities designed to protect and promote the health and well being of students and school staff. A coordinated school health program utilizes personnel, agencies and programs, both in and out of the school building, which relate to student health and success in school.

The Kansas Department of Health and Environment, Children & Families Section, and the Kansas State Department of Education are in agreement that schools by themselves cannot, and should not be expected to address the state's most serious health and social problems. Families, private health care providers, local health departments, religious organizations, the media, community organizations working with children and families, as well as youth themselves, must be systematically involved. The schools do, however, provide the critical point at which multiple agencies can come together to establish and maintain the well-being of children and families.

The eight components of a Coordinated School Health Program address the whole child and community in this effort, and thus provide the framework for school health services endorsed by both the Kansas Department of Health and Environment (KDHE) and the Kansas State Department of Education (KSDE) for the 21st century. The Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH) is recognized by KDHE and KSDE as the definitive resource on Coordinated School Health Programs. The website and links can be found at www.cdc.gov/nccdphp/dash/cshpdef.htm.

The National Association of School Nurses defines the eight components of a Coordinated School Health Program as follows:

- ***School health services:*** Preventive services, education, emergency care, referral and management of acute and chronic health conditions. Designed to prevent health problems, promote health, assess health status, provide emergency care, ensure access to health care and identify and manage barriers to students' learning.
- ***Health education:*** A planned, sequential K through 12 curriculum addressing the physical, mental, emotional and social dimensions of health, to help students develop health knowledge, attitudes and skills. Designed to motivate students to maintain and/or improve their health status, prevent disease and reduce at-risk behaviors.
- ***Health promotion programs for faculty and staff:*** Planned health promotion and disease prevention programs and opportunities for school staff. Designed to maintain and improve health status, strengthen morale and enhance their effectiveness in working with students.
- ***Counseling psychological and social services:*** Services that focus on cognitive, emotional, behavioral and social needs of individuals and families. Designed to prevent and address problems, to enhance learning and healthy behavior and to promote a positive school climate.
- ***School nutrition services:*** Integration of nutritious, affordable and appealing meals, nutritional education and an environment that promotes healthy eating behaviors for all students. Designed to maximize each student's education and lifelong health potential.
- **Physical education programs:** A planned, sequential K through 12 curriculum that promotes lifelong physical activity. Designed to develop basic movement skills, sports skills and physical fitness and to enhance mental, social and emotional abilities.
- ***Healthy school environment:*** A safe physical and psychological environment that is supportive of learning.
- ***Family and community involvement:*** Partnerships among schools, families, community groups and individuals. Designed to share and maximize resources and expertise in addressing the healthy development of children and families.

The Kansas Coordinated School Health Program was established in 2003 and you can visit their website at:
http://www.kshealthykids.org/ for more information. Contact Melissa Brooks at mbrooks@ksde.org or call 785-296-1473 or Allison Koonce at akoonce@kdhe.state.ks.us or call 785-296-1949.

School Nurse Leadership in Coordinated School Health Programs

Coordinated School Health Services—or at least pieces of them—exist already in many schools. What is lacking is a truly concerted effort to bring these services together.
The National Association of School Nurses has published a position statement on Coordinated School Health, asserting that the school nurse is in a unique position to assume a leadership role in these programs. The position statement can be found at:
http://www.nasn.org/positions/2003pscoordinated.pdf

The American Academy of Pediatrics in 2001 published a policy statement on the **Role of the School Nurse in Providing School Health Services,** which can be found at www.aap.org/policy/re0050.html. This statement supports the central management role of the school nurse in the implementation of the school health services program for all children and youth in the school. Ideally, the school nurse will collaborate with primary care physicians, specialists, and local public health and social service agencies to ensure a full spectrum of effective and quality services that sustain children, youth, and their families.

The School Health Policy and Programs Study (SHPPS)
www.cdc.gov/nccdphp/dash/shpps/index.htm is a **national survey** periodically conducted by the CDC to assess school health policies and programs at the state, district, school, and classroom levels. SHPPS is used to monitor the status of the nation's school health policies and programs; describe the professional background of the personnel who deliver each component of the school health program; describe relationships between state and district policies and school health programs and practices; and identify factors that facilitate or impede delivery of effective school health programs.

The School Health Index is an excellent example of a self assessment and planning tool that enables schools to Identify the strengths and weaknesses of the school's health promotion policies and programs, develop an action plan for improving student health, and involve teachers, parents, students, and the community in improving school services. Six health risk behaviors have been identified as being largely responsible for the leading causes of death and illness among young people and adults in the United States:

- Physical inactivity
- Poor eating habits
- Tobacco use
- Risky sexual behavior
- Behaviors that result in intentional or unintentional injury
- Alcohol and other drug abuse

Because these behaviors are often established in childhood, positive choices must be promoted early in life. The first version of the School Health Index addresses physical activity and healthy eating. Future versions will address the other key health behaviors. The School Health Index for Physical Activity and Healthy Eating can be found at: www.cdc.gov/nccdphp/dash/SHI/index.htm where you can download and print the Index for Elementary Schools, or for Middle and High Schools.

The website at www2.edc.org/themes/specific.asp?9 links to the Education Development Center (EDC). EDC designs and evaluates programs that foster the physical, social, and emotional well-being of people in a variety of conditions around the world. In partnership with education, criminal justice, health care, and community institutions, they emphasize comprehensive, integrated approaches to health promotion across the lifespan. In addition, they work to prevent specific diseases and afflictions, including alcohol, tobacco, and drug abuse; violence and injuries; and HIV infection and other sexually transmitted diseases. You can access information on specific EDC projects relating to disease prevention, community building, women's health, school health, nutrition, injury prevention, etc. at this site as well.
www2.edc.org/MakingHealthAcademic/cshp.asp.

Other excellent resources on Coordinated School Health Programs include:
Health is Academic: A Guide to Coordinated School Health Programs by Eva Marx (Editor), 1998. This book provides a concise and complete map to understanding and developing coordinated school health programs.

Schools and Health: Our Nation's Investment by Diane Allensworth (Editor), 1997. Schools and Health is an Institute of Medicine (IOM) publication available on line in readable format at www.nap.edu/books/0309054354/html/. The document can be printed in readable format as well by following the PRINT directions at the bottom of the page.

Health Education

Health education for infants involves the preconceptional, prenatal, and postnatal periods. Preconceptionally, nurses working in and with schools have a unique opportunity to educate prospective parents about the benefits of making healthy choices before conception. Those choices can significantly improve pregnancy outcomes for both parents and infant. For example, the risk of certain congenital abnormalities can be mitigated by the mother-to-be consuming adequate amounts of folic acid before and during pregnancy. Fetal alcohol syndrome, the most common known cause of mental retardation in the US is preventable with appropriate preconceptual health education. Smoking contributes to low birthweight infants. Offering preconceptional guidance to adolescents and young adults—the parents of the future—can contribute considerably to the development of healthy adults, healthy pregnancies, and healthy infants.

Health education is a powerful tool for educating families in the prenatal period and affecting health outcomes for infants and parents. Educating future parents about lifelong health issues such as the importance of a healthy diet and physical activity, and avoidance of alcohol, drug and tobacco use is particularly effective during this time.

Postnatally, parents tend to be very open to health education concerning the healthy development of their newborn and what to expect over the next years of the child's life. A major component of health education during this period concerns counseling regarding temperament, colic, temp tantrums and sleep disturbances, especially for parents of sensitive or difficult infants, or very young parents. Health education can have a significant impact on the interaction between parent and infant. Helping parents to understand their child's temperament can help them respond more effective to their infant and create a healthy relationship.

Health education in the context of child and adolescent health refers to a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum should be designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It should allow students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. A comprehensive curriculum will include a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.

Kansas requirements for health education in schools are currently limited to:

- **KAR 91-31-32 (c) (9) (G) Human sexuality (Effective July 1, 2005)**
  (a) Each school shall be assigned its accreditation status based upon the extent to which the school has met the performance and quality criteria established by the state board in this regulation.
  (9) programs and services to support learning and growth at both elementary and secondary levels, including the following:
  (G) physical education, which shall include instruction in health and human sexuality;

Clearly, these regulations do not even begin to address the health and lifestyle issues children and adolescents must deal with a daily basis. It is the position of KDHE Children and Families that nurses working in and with schools are in a unique position to assist school districts in developing comprehensive health education programs that promote a healthy lifestyle and responsible behaviors.

Safety and Injury Prevention

During the last century, trauma replaced infectious disease as the greatest threat to children. In recent years, traumatic injury has begun to receive long overdue recognition as a major public health problem. Attention has been focused on the toll of lives lost; however, it is clear that deaths represent only a small fraction of total injuries. National data for the period from 1995-1998 indicate that for every one injury death there are 18 injury related hospital discharges and 260 emergency department visits. In 1999, there were 1,026 unintentional injury deaths in Kansas according to vital statistics records. Persons in predominately rural areas are at higher risk for injury death or disability than more urbanized areas due to delays in discovery, longer response times or limited availability, greater distances to care facilities, and limited access to specialty resources.

In 1999 the legislature passed legislation (KSA 75-5663 to 75-5670) establishing an Advisory Committee on Trauma and designated the Department of Health and Environment as the administering agency for a state trauma program. The Secretary of KDHE was charged with the development of a statewide trauma system plan, establishment of regional trauma councils and implementation of a statewide trauma registry, all in consultation with the Advisory Committee on Trauma (ACT). The ACT has representation from a variety or professional organizations with expertise in trauma care including hospital association, medical society, EMS, nurse association and legislators. KDHE is responsible for the development of rules and regulation necessary to carry out the act.

Ideally, trauma would be prevented, rather than treated. Awareness and education are essential components of any prevention program. The **Kansas SAFE KIDS Coalition** http://www.kdhe.state.ks.us/safekids/ has been a leader in promoting child health and safety in Kansas. The Safe Kids Coalition is a group of more than 60 organizations and businesses from throughout the state that have joined together to prevent unintentional injury. The Coalition is affiliated with the **National SAFE KIDS Campaign,** and is facilitated by staff at **KDHE Injury and Disability Programs** http://www.kdhe.state.ks.us/idp/

NASN has a number of position statements available on injury prevention and safety issues including:

- Backpacks http://www.nasn.org/positions/2001psbackpacks.pdf
- Healthy School Environment http://www.nasn.org/positions/1998pshealthy.pdf
- Seatbelts http://www.nasn.org/positions/2001psseatbelts.pdf
- Sun Protection http://www.nasn.org/positions/2000pssun.pdf